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ORIGINAL

LEGISLATIVE HISTORY
TITLES I-XX
OF THE
SOCIAL SECURITY ACT

VOLUME XIX
96TH CONGRESS
1979-1980

COMPLETED
961

ORIGINAL

Legislative History of Titles I-XX of the Social Security Act

Volume XIX
96th Congress
1979-1980

Compiled by the
Technical Documents Branch
Division of Technical Documents and Privacy
Office of Regulations
Office of Operational Policy and Procedures
Social Security Administration

I

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PREFACE

This legislative history has been prepared to provide a convenient reference source for studies of the development of the provisions of the Social Security Act as amended by the 96th Congress, which adjourned on December 16, 1980.

The legislative history began with the Social Security Act, as enacted on August 14, 1935, and pertained only to the benefit programs (titles II, XVI, and XVIII) administered by the Social Security Administration. Beginning with the legislative history of the 95th Congress, the history has been expanded to include the 20 titles of the Social Security Act.

This legislative history includes:

.Every enactment of the 96th Congress affecting or adding to the provisions of the Social Security Act.

.Relevant committee reports of the House of Representatives and the Senate relating to the Social Security Act.

Excerpts were substituted for the full text where pertinent.

In some instances the House and Senate reports accompanying a particular act will not reflect one or more provisions contained in the act. This is usually due to the fact that the particular provision was added to the bill on the floor of the House, or Senate, as the case may be, after issuance of the particular report. In these cases, background material relating to the amendment may be found in the Congressional Record report of the House or Senate debate on the bill. The Congressional Record may also provide a useful supplemental reference source even in those cases in which the House or Senate report discusses the particular provision in which the researcher is interested. It is not feasible to reproduce in this legislative history the thousands of pages of the Congressional Record carrying the House and Senate debates with respect to the acts included in the history. However, on the last page of each public law contained in this volume, appears a listing of the dates on which the act was considered in the House and Senate, and the volume of the Congressional Record in which such debate may be found.

The material included in this legislative history is an exact photo-reproduction of the original documents.

Finder's Aid

P.L. 96-32 (93 Stat. 82) Approved July 10, 1979
Public Health Service Act, Amendment

Subject	SS Act Section	P.L. Section	93 Stat.	H.Rep. 96-187	No other reports
Technical Amendment Change Plural to Singular	1122	2(c)	82	12	

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PUBLIC HEALTH SERVICE ACT, AMENDMENT

Public Law 96-32
96th Congress

Joint Resolution

July 10, 1979
[S.J. Res. 14]

To amend the Public Health Service Act and related health laws to correct printing and other technical errors.

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) paragraph (3)(B) of subsection (b) of the first section of Public Law 95-613 (92 Stat. 3093) is amended by striking out "1979; $3,600,000 for the fiscal year ending September 30, 1980;" and inserting in lieu thereof "1979, $120,800,000 for the fiscal year ending September 30,".

Public Health Service Act, amendment
42 USC 300a-2.

(b) The amendment made by subsection (a) shall be effective as of November 8, 1978.

Effective date
42 USC 300a-2 note.

SEC. 2. (a) Section 3(c)(2)(B) of the Health Maintenance Organization Amendments of 1978 (Public Law 95-559) is amended by inserting "of this subsection" after "paragraph (3)".

42 USC 300e-3.

(b) Section 11(a) of such Amendments is amended by striking out "section 1310(b)" and inserting in lieu thereof "section 1301(b)".

42 USC 300e.

(c) Section 14(b)(1) of such Amendments is amended by striking out "organizations" and inserting in lieu thereof "organization".

42 USC 1320a-1.

(d) Section 1305(b)(1) of the Public Health Service Act (42 U.S.C. 300e-4(b)(1)) (as amended by section 4(a)(1) of such Amendments) is amended by striking out "$4,000,000" each place it occurs and inserting in lieu thereof "$4,500,000".

(e) Section 1305A(c)(1) of the Public Health Service Act (42 U.S.C. 300e-4(c)(1)) (as added by section 5 of such Amendments) is amended by striking out "The" and inserting in lieu thereof "the".

42 USC 300e-4a.

(f) Section 1310(e)(1) of the Public Health Service Act (42 U.S.C. 300e-9(e)(1)) is amended by striking out "subsection (a)" and inserting in lieu thereof "subsection (a), (b), or (c)".

SEC. 3. (a) Section 504(b)(3) of the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978 (Public Law 95-602) is amended by striking out "to the" and inserting in lieu thereof "for the".

42 USC 6081.

(b) Section 506(a)(3) of such Amendments is amended by striking out "that such State" and inserting in lieu thereof "that each State".

42 USC 6009.

SEC. 4. Section 1802 of the Public Health Service Act (42 U.S.C. 300v-1) (added by section 301 of Public Law 95-622) is amended by striking out "(b) DEFINITIONS" and inserting in lieu thereof "(f) DEFINITIONS".

SEC. 5. (a) Section 3(b) of the Health Services Research, Health Statistics, and Health Care Technology Act of 1978 (Public Law 95-623) is amended by striking out "second time" and inserting in lieu thereof "third time".

42 USC 242b.

(b) Section 3(d) of such Act is amended by striking out "Section 304(d)(3)" and inserting in lieu thereof "Section 304(b)(3)".

(c) Subsection (e) of section 304 of the Public Health Service Act (42 U.S.C. 242c(e)) (added by section 7 of the Health Services Research, Health Statistics, and Health Care Technology Act of 1978) is redesignated as subsection (d).

42 USC 242b.

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(n) Section 1701(b) of the Public Health Service Act (42 U.S.C. 300u(b)) is amended by inserting "(other than grants and contracts under sections 1707, 1708, and 1709)" after "this title". 42 USC 300u-6, 300u-7, 300u-8.

SEC. 8. (a)(1) Section 103 of the Community Mental Health Centers Extension Act of 1978 (Public Law 95-622) is amended by adding at the end the following new subsection: Effective date. 42 USC 2689b note.

"(c) The amendments made by this section shall take effect with respect to grants made under section 203 of the Community Mental Health Centers Act from appropriations made for fiscal years ending after September 30, 1977." 42 USC 2689b.

(2) Section 110(b) of Public Law 95-622 is amended (A) by inserting "(1)" after "(b)", and (B) by adding at the end the following: Effective date. 42 USC 2689b note.

"(2) The amendment made by paragraph (1) shall take effect with respect to grants made under section 203(e) of the Community Mental Health Centers Act from appropriations made for fiscal years ending after September 30, 1977."

(3) Section 111 of Public Law 95-622 is amended by striking out "section 110(c)" and inserting in lieu thereof "sections 103, 110(b)(1), and 110(c)". 42 USC 2689 note. 42 USC 2689b, 2689m.

(b) Section 206(c)(2)(B) of the Community Mental Health Centers Act (42 U.S.C. 2689e(c)(2)(B)) is amended by inserting "and" at the end of clause (iii).

Approved July 10, 1979.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 96-187 (Comm. on Interstate and Foreign Commerce).
CONGRESSIONAL RECORD, Vol. 125 (1979):
Jan. 18, considered and passed Senate.
June 25, considered and passed House, amended.
June 27, Senate agreed to House amendments.

96TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
No. 96-187

TECHNICAL CORRECTIONS TO HEALTH LAWS

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

[To accompany S.J. Res. 14]

[Including cost estimate of the Congressional Budget Office]

MAY 15, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1979

[redacted]

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ber 30, [1979; $3,600,000 for the fiscal year ending September 30, 1980;] *1979, $120,800,000 for the fiscal year ending September 30,* 1980, and $138,900,000 for the fiscal year ending September 30, 1981".

* * * * * * *

Health Maintenance Organization Amendments of 1978

AN ACT To amend the Public Health Service Act to revise and extend the program of assistance under that Act for health maintenance organizations.

* * * * * * *

INITIAL DEVELOPMENT

SEC. 3. (a) * * *

* * * * * * *

(c)(1) Subparagraph (A) of section 1304(f)(2) is amended to read as follows:

"(A) $1,000,000 through September 30, 1979, and $2,000,000 thereafter, or".

(2) Section 1304(f) is amended—

(A) by striking out "The amount" in paragraph (2) and inserting in lieu thereof "Except as provided in paragraph (3), the amount";

(B) by striking out "(except as provided in paragraph (3) *of this subsection*)" in paragraph (2); and

* * * * * * *

REQUIREMENTS FOR THE PROVISION OF SERVICES

SEC. 11. (a) Paragraph (3) of section [1310] *1301*(b) is amended to read as follows:

"(3)(A) * * *

* * * * * * *

AMENDMENTS TO THE SOCIAL SECURITY ACT

SEC. 14. (a)(1) * * *

* * * * * * *

(b) Section 1122 of the Social Security Act is amended—

(1) by striking out "or health maintenance [organizations] *organization*" each place it occurs,

(2) by striking out "or health maintenance organizations" each place it occurs, and

(3) by striking out "or organization, or of any facility of such organization," in subsection (d)(2).

* * * * * * *

Finder's Aid

P.L. 96-79 (93 Stat. 592) Approved October 4, 1979
Health Planning and Resources Development Amendments of 1979

Subject	SS Act Section	P.L. Section	93 Stat.	H.Rep. 96-190	H.C.Rep. 96-420	S.Rep. 96-96	S.C.Rep. 96-309
Technical Amendment	1903(m)(2)(C)	128	629				
Health Maintenance Organization Enrollment				91 119	83, 95	43	96-97

BEST DOCUMENT AVAILABLE

HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1979

Public Law 96-79
96th Congress

An Act

Oct. 4, 1979
[S. 544]

To amend titles XV and XVI of the Public Health Service Act to revise and extend the authorities and requirements under those titles for health planning and health resources development, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Health Planning and Resources Development Amendments of 1979.

SHORT TITLE; REFERENCES TO PUBLIC HEALTH SERVICE ACT; AND TABLE OF CONTENTS

42 USC 201 note.

SECTION 1. (a) This Act may be cited as the "Health Planning and Resources Development Amendments of 1979".

Post, pp. 607, 629.

(b) Whenever in this Act (other than in subsections (j) and (k) of section 115 and in section 128) an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

42 USC 201 note.

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TITLE II—REVISION OF AUTHORITY FOR HEALTH RESOURCES DEVELOPMENT

Sec. 201. Revision and extension of assistance.
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Sec. 203. Technical amendments.
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TITLE III—PROGRAM TO ASSIST AND ENCOURAGE THE DISCONTINUANCE OF UNNEEDED HOSPITAL SERVICES

Sec. 301. Authorization of program.
Sec. 302. Study.

TITLE I—REVISION OF HEALTH PLANNING AUTHORITY

REVISION AND REPORTING ON NATIONAL GUIDELINES FOR HEALTH PLANNING

SEC. 101. (a)(1)(A) Section 1501 is amended (i) by striking out "and shall, as he deems appropriate, by regulation revise such guidelines" in subsection (a), and (ii) by adding after subsection (c) the following: 42 USC 300k-1.

"(d) The Secretary shall, on an annual basis, review the standards and goals included in the guidelines issued under subsection (a). In conducting such a review, the Secretary shall review the health systems plans and annual implementation plans of health systems agencies and State health plans. If the Secretary proposes to revise a guideline issued under subsection (a), he shall make such revision by regulations promulgated in accordance with section 553 of title 5, United States Code.

"(e)(1) The Secretary may collect data to determine whether the health care delivery systems meet or are changing to meet the goals included in health systems plans under section 1513(b)(2) and State health plans under section 1524 and to determine the personnel, facilities, and other resources needed to meet such goals. The Secretary shall prescribe (A) the manner in which such data shall be assembled and reported to the Secretary by health systems agencies, State health planning and development agencies, and other entities, and (B) the definitions which shall be used by such agencies and entities in assembling and reporting such data. 42 USC 300*l*-2. 42 USC 300m-3.

"(2) The Secretary shall from the data collected under paragraph (1) periodically make public a (A) statement of the relationship between the goals contained in the health systems plans and the State health plans and the status of the supply, distribution, and organization of health resources with respect to which such goals were established, and (B) summary of changes (either through additions or reductions) in resources needed to meet such goals.".

(B) The amendments made by subparagraph (A) do not authorize the enactment of new budget authority before October 1, 1979. Budget authority. 42 USC 300k-1 note.

(2) Subsection (b)(1) of section 1501 is amended by adding at the end thereof the following: "Such standards shall reflect the unique circumstances and needs of medically underserved populations in isolated rural communities.". 42 USC 300k-1.

(3) Subsection (c) of section 1501 is amended by striking out "In issuing guidelines under subsection (a) the Secretary shall" and inserting in lieu thereof "At least 45 days before the initial publication of a regulation proposing a guideline under subsection (a) or a revision under subsection (d) of such a guideline, the Secretary shall, with respect to such proposed guideline or revision,".

(b)(1) Section 1513(b)(1) is amended by adding after and below subparagraph (F) the following: 42 USC 300*l*-2.

AUTHORIZATIONS

SEC. 127. (a) Section 1516(d)(1) (as amended by section 106) is amended— *Ante*, p. 598.

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $150,000,000 for the fiscal year ending September 30, 1980, $165,000,000 for the fiscal year ending September 30, 1981, and $185,000,000 for the fiscal year ending September 30, 1982".

(b) Section 1525(c) is amended— 42 USC 300m-4.

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $35,000,000 for the fiscal year ending September 30, 1980, $40,000,000 for the fiscal year ending September 30, 1981, and $45,000,000 for the fiscal year ending September 30, 1982".

(c) Section 1526(e) is amended— 42 USC 300m-5.

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $6,000,000 for the fiscal year ending September 30, 1980, $6,000,000 for the fiscal year ending September 30, 1981, and $6,000,000 for the fiscal year ending September 30, 1982".

(d) Section 1534(d) is amended— 42 USC 300n-3.

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $6,000,000 for the fiscal year ending September 30, 1980, $8,000,000 for the fiscal year ending September 30, 1981, and $10,000,000 for the fiscal year ending September 30, 1982".

(e) Section 1640(d) is amended— 42 USC 300t.

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $20,000,000 for the fiscal year ending September 30, 1981, and $30,000,000 for the fiscal year ending September 30, 1982".

TECHNICAL AMENDMENT

SEC. 128. Section 1903(m)(2)(C) of the Social Security Act is amended by striking out "the date the entity enters into a contract with the State under this title for the provision of health services on a prepaid risk basis" and inserting in lieu thereof "the date the entity qualifies as a health maintenance organization (as determined by the Secretary)". 42 USC 1396b.

EFFECTIVE DATE

SEC. 129. (a) The amendments made by this title (other than by sections 101, 102, 103(a), 103(b), 103(c), 104(c), 105, 106, 107, 110(c), 110(d), 110(e), 110(f), 111, 115(f), 116(d), 116(e), 117, 120, 123, 126, 127, and 128) shall take effect one year after the date of the enactment of this Act, except that on and after the date of the enactment of this Act— 42 USC 300*l* note.

(1) the changes in the membership of the health systems agencies and the Statewide Health Coordinating Councils required by amendments to sections 1512, 1524, and 1531 shall be implemented through selections of members to fill vacancies occurring after such date, 42 USC 300*l*-1, 300m-3, 300n.

(2) a health systems agency, a State health planning and development agency, and a Statewide Health Coordinating Council may make the organizational and related changes required by

"AUTHORIZATION OF APPROPRIATIONS

42 USC 300t-14
Ante, pp. 637, 639

"SEC. 1644. To make payments under grants under sections 1642 and 1643 there are authorized to be appropriated $30,000,000 for the fiscal year ending September 30, 1980, $50,000,000 for the fiscal year ending September 30, 1981, and $75,000,000 for the fiscal year ending September 30, 1982, except that in any fiscal year not more than 10 percent of the amount appropriated under this section may be obligated for grants under section 1643.".

42 USC 300s-3.
Ante, p. 632.
Ante, p. 637

(b) Section 1624 is amended by striking out "For purposes of this title" and inserting in lieu thereof "Except as provided in section 1642(e), for purposes of this title".

STUDY

Unneeded hospital services, elimination.
42 USC 300t-11 note.
Ante, p. 636.
Report to Congress.

SEC. 302. The Secretary of Health, Education, and Welfare shall conduct a study of the effect on the elimination of unneeded hospital services made during the two fiscal year period ending September 30, 1981, by the program authorized by part E of title XVI of the Public Health Service Act. The Secretary shall not later than January 1, 1982, report the results of the study to Congress together with his recommendations for any revisions in the program under such part E which he determines to be appropriate, including any revision in the authorizations of appropriations for grants under such program.

Approved October 4, 1979.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 96-190 accompanying H.R. 3917 (Comm. on Interstate and Foreign Commerce) and No. 96-420 (Comm. of Conference).
SENATE REPORTS: No. 96-96 (Comm. on Labor and Human Resources) and No. 96-309 (Comm. of Conference).
CONGRESSIONAL RECORD, Vol. 125 (1979):
May 1, considered and passed Senate.
July 19, H.R. 3917 considered and passed House; passage vacated and S. 544, amended, passed in lieu.
Sept. 20, House agreed to conference report.
Sept. 21, Senate agreed to conference report.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 15, No. 40:
Oct. 4, Presidential statement.

Union Calendar No. 114

96TH CONGRESS
1st Session } HOUSE OF REPRESENTATIVES { REPORT
No. 96-190

HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1979

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

together with

ADDITIONAL VIEWS

[To accompany H.R. 3917]

[And Including Cost Estimate of the Congressional Budget Office]

MAY 15, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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WASHINGTON : 1979

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review of their anticipated applications for full designation or requests for waiver allowing their conditional designation beyond 24 months. It is concerned, however, that only some rather than all agencies were site assessed prior to their full designation (or approval of waiver requests), and that there is evidence that careful, ongoing monitoring of State and local agencies is not carried out effectively in all parts of the country.

The committee is also concerned about the lack of an agency reporting system. Without such a system not only is the Department handicapped in its management and monitoring of the health planning program, but congressional committees are forced to rely on incomplete, dated, and frequently little more than hearsay information on the structure, operations, and performance of health systems and State agencies in their deliberations. It is incumbent, therefore, that the Secretary of Health, Education, and Welfare and the Director of the Office of Management and Budget ensure the swift development of reporting mechanisms that will provide needed information. In this regard, this committee wishes to call attention to its 1974 report which accompanied the original legislation.

> The committee is further aware of the appalling difficulty which the program in the Department has had in getting clearance for the reporting system and the forms to be used in it through the Department and the Office of Management and Budget.

This situation apparently has not been corrected.

TECHNICAL AMENDMENT

The Health Maintenance Organization Amendments of 1976, Public Law 94-460 provided that a health maintenance organization (HMO) could participate in Medicaid on a prepaid risk basis only if it was qualified under Title XIII of the Public Health Service Act if no more than 50 percent of its enrolled population was Medicare and Medicaid recipients. The law provided that an HMO could have up to three years to meet this requirement, provided it was making progress in enrolling non-Medicaid and Medicare enrollees. The three year period started on the date the organization entered into a prepaid risk contract with the State Medicaid agency or on the date the amendment was passed, which ever was later. For those organizations which already had contracts to cover Medicaid recipients that effectively gave them until October 8, 1979 to comply with the provision. Many of the organizations which believed they could qualify as HMOs applied to HEW for qualification. However, in the case of at least one of the HMOs HEW took 18 months to complete the qualification review process and that organization's efforts to enroll non-Medicaid individuals was severely hampered. It is now in danger of failing to meet the 50 percent requirement.

The committee proposal includes an amendment to the Social Security Act that would allow an organization three years from the time it received HEW qualification to meet the requirements of the law concerning the enrollment of non-Medicaid enrollees. This will counter any disadvantage which an organization received because of the delays in the HEW qualification process.

million), and fiscal year 1981 ($11 million), and for fiscal year 1982 ($12 million).

Section 124(e) amends section 1640(d) and authorizes support for the area health services development fund in fiscal year 1980 ($25 million), and fiscal year 1981 ($40 million) and for fiscal year 1982 ($50 million).

Section 125. Report on effectiveness of planning law

Section 125 requires the Secretary to report to the Congress on the results of his review under section 1535 to determine the extent to which it may be demonstrated that: (A) the health of the residents in the area has been improved; (B) the accessibility, acceptability, continuity and quality of health care has been improved; and (c) increases in costs of the provision of health care have been restrained.

Section 126. Technical amendments

Section 126 amends section 1903(m)(2)(c) of the Social Security Act to allow a health maintenance organization three years from the time it is qualified to meet the requirement that at least 50 percent of an HMO's enrolled population must be made up of other than Medicare and Medicaid recipients.

Section 127. Effective date

Section 127 provides that these amendments shall take effect one year after the date of enactment of the Act except that health systems agencies, State health planning and development agencies and Statewide Health Coordinating Councils may act to make changes in their structure and functions required by the amendments prior to that date. Required membership changes can be made as vacancies occur. The amendments made by section 117 shall take effect 180 days after the date of enactment unless a change in State law is required in which case the amendments shall take effect in such State after the close of the first regular session of the legislature which begins after the promulgation of the regulations under section 117(e).

Title II—Revision of Authority for Health Resources Development

Section 201. Revision and extension of assistance

Section 201(a) repeals Part B of Title XVI "Allotments."

Section 201(b) restructures the loan and loan guarantee provisions of section 1620 to provide assistance for projects in the following priority areas:

1. Modernization of medical facilities.
2. Construction of new outpatient medical facilities.
3. Construction of new hospitals in (a) areas of rapid population or (b) areas where merger or closure of medical facilities results in a reduction of hospital beds.
4. Conversion of existing medical facilities to outpatient medical facilities or facilities for long term care.

This section also limits the 3 percent interest subsidy to loans and loan guarantees made to facilities in rural and urban poverty areas.

Section 201(c) amends section 1625 by entending the authorization for the project grant program for construction or modernization

The purpose of Certificate of Need programs is to insure that new health services are not offered and new health facilities are not built unless they are needed. Certificate of Need review was never intended to be used as a means of eliminating existing services, altering hospital boards of trustees, or forcing hospitals and other providers to take actions which are unrelated to the service for which an application is made.

DAVID E. SATTERFIELD III.
PHIL GRAMM.
RICHARD SHELBY.
WILLIAM E. DANNEMEYER.
EDWARD R. MADIGAN.
JAMES T. BROYHILL.
GARY A. LEE.
DAVE STOCKMAN.

96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 96–420

HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS, 1979

SEPTEMBER 5, 1979.—Ordered to be printed

Mr. STAGGERS, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany S. 544]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 544) to amend titles XV and XVI of the Public Health Service Act to revise and extend the authorities and requirements under those titles for health planning and resources development, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

SHORT TITLE; REFERENCES TO PUBLIC HEALTH SERVICE ACT; AND TABLE OF CONTENTS

SECTION 1. (a) This Act may be cited as the "Health Planning and Resources Development Amendments of 1979".

(b) Whenever in this Act (other than in subsections (j) and (k) of section 115 and subsection (a) of section 128) an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

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SEC. 1. Short title; references to Public Health Service Act; and table of contents.

TITLE I—REVISION OF HEALTH PLANNING AUTHORITY

Sec. 101. Revision and reporting on national guidelines for health planning.
Sec. 102. National health priorities; National Council on Health Planning and Development.

Sec. 103. The role of competition in the allocation of health services.
Sec. 104. Designation of health service areas.
Sec. 105. Designation of health systems agencies.
Sec. 106. Planning grants.
Sec. 107. Carryover of grant funds.
Sec. 108. Membership requirements.
Sec. 109. Governing body selection.
Sec. 110. Responsibilities of governing bodies.
Sec. 111. Meetings and records.
Sec. 112. Support and reimbursement for members of governing bodies.
Sec. 113. Conflicts of interest.
Sec. 114. Staff expertise.
Sec. 115. Health plan requirements.
Sec. 116. Criteria and procedures for reviews.
Sec. 117. Certificate of need programs.
Sec. 118. Appropriateness review.
Sec. 119. Review and approval of proposed uses of Federal funds.
Sec. 120. Coordination of health planning with rate review.
Sec. 121. Coordination within standard metropolitan statistical areas and with other entities.
Sec. 122. Collection and publication of hospital charges.
Sec. 123. State health planning and development agencies.
Sec. 124. Statewide Health Coordinating Council composition.
Sec. 125. Centers for health planning.
Sec. 126. Definitions.
Sec. 127. Authorizations.
Sec. 128. Technical amendment.
Sec. 129. Effective date.

TITLE II—REVISION OF AUTHORITY FOR HEALTH RESOURCES DEVELOPMENT

Sec. 201. Revision and extension of assistance.
Sec. 202. Conforming amendments.
Sec. 203. Technical amendments.
Sec. 204. Effective date.

TITLE III—PROGRAM TO ASSIST AND ENCOURAGE THE DISCONTINUANCE OF UNNEEDED HOSPITAL SERVICES

Sec. 301. Authorization of program.
Sec. 302. Study.

TITLE I—REVISION OF HEALTH PLANNING AUTHORITY

REVISION AND REPORTING ON NATIONAL GUIDELINES FOR HEALTH PLANNING

SEC. 101. (a)(1)(A) Section 1501 is amended (i) by striking out "and shall, as he deems appropriate, by regulation revise such guidelines" in subsection (a), and (ii) by adding after subsection (c) the following:

"(d) The Secretary shall, on an annual basis, review the standards and goals included in the guidelines issued under subsection (a). In conducting such a review, the Secretary shall review the health systems plans and annual implementation plans of health systems agencies and State health plans. If the Secretary proposes to revise a guideline issued under subsection (a), he shall make such revision by regulations promulgated in accordance with section 553 of title 5, United States Code.

"(e)(1) The Secretary may collect data to determine whether the health care delivery systems meet or are changing to meet the goals included in health systems plans under section 1513(b)(2) and State

tractual arrangement thirty days after the filing of the purchaser's required notice to the State Agency of intent to acquire such equipment.

Coverage of health maintenance organizations

The Senate bill establishes special criteria under which certificate of need applications of health maintenance organizations will be reviewed and approved. Applications of Federally qualified HMO's for new institutional health services must be approved by the State agency if it finds that (1) approval is required to meet the needs of present HMO members and new members who can reasonably be expected to enroll, and (2) that the HMO is unable to provide, through services or facilities which can reasonably be expected to be available to the organization, its institutional health services in a reasonable and cost effective manner consistent with the basic method of operation of the HMO and which makes such services available on a long term basis through physicians and other health professionals associated with the HMO. It further provides that no certificate of need program shall have provisions for the review and determination of need of the services, facilities, equipment and organization of health maintenance organizations and the entities through which their services are provided except for new institutional health services of hospitals controlled directly or indirectly by health maintenance organizations and diagnostic and therapeutic equipment of health maintenance organizations (section 148 and section 136).

The House amendment requires a State to exempt from its certificate of need program the development of new institutional health services, the acquisition of major medical equipment and the obligation of capital expenditures of (1) a health maintenance organization, (2) any other provider of health care which provides ambulatory and inpatient health services on a prepaid basis if at least 75 percent of the patients who use the service or equipment which is exempt are enrollees of the organization or provider and (3) any other provider who has entered into agreements to serve enrollees of an HMO or other providers (described in 2 above) if at least 75 percent of the annual revenues from the service, equipment, or expenditure are derived from such agreements.

If in any year an exempt HMO or provider fails to meet the 75 percent patient or revenue requirement, the State shall prohibit the HMO or provider from using the service, equipment or expenditure to provide services to individuals other than those enrolled on a prepaid basis with the HMO or provider. Notice shall be provided to the Secretary and the State Medicaid agency that the provider is prohibited from using the service, equipment or expenditure to provide services to individuals who are entitled to benefits under Titles XVIII and XIX of the Social Security Act unless the individuals are enrolled on a prepaid basis with an HMO or other exempt provider. The House amendment also provides that the certificate of need program may apply to an HMO only to the extent that it is not exempt and then only to the acquisition of major medical equipment, the offering of new institutional health services, and the obligation of capital expenditures as required in Title XV (section 117(a)).

The conference substitute, as a compromise, provides that a certificate of need program may not require a certificate of need for the

TECHNICAL AMENDMENT

Percentage of HMO enrollees

The House amendment contains a provision amending section 1903 (m) (2) (c) of the Social Security Act to allow a health maintenance organization three years from the time it is qualified to meet the requirement that at least 50 percent of an HMO's enrolled population be made up of other than Medicare and Medicaid recipients (section 126).

The conference substitute conforms to the House amendment (section 128).

Miscellaneous amendments

The Senate bill contains a provision, not included in the House amendment, which repeals section 314 (a), (b) and (c) and Title 9 in its entirety.

The conference substitute conforms to the Senate bill.

Report on effectiveness of planning law

The House amendment contains a provision, not included in the Senate bill, which specifies that the Secretary shall report to the Congress on the results of the review conducted pursuant to Section 1535 respecting improvements in health and health care and restraints on increases in health care costs (section 125).

The conference substitute conforms to the Senate bill.

EFFECTIVE DATES

The Senate bill provides that amendments to Title XV shall take effect on the date of enactment of this Act, except that certain amendments shall take effect one year from the date of enactment and other amendments shall take effect six months from the date of enactment except that on or after the date of enactment, the HSA's, the State Agencies, and the SHCC's, may make the organizational and related changes required and may act in accordance with the changes in their functions made by such amendments (section 157).

The House amendment provides that certain amendments shall take effect one year after the date of enactment except that on or after the date of enactment, the changes in membership of the HSA's and the SHPDA's shall be implemented through selection of members to fill vacancies occurring after such date, except that the HSA (the State Agency and the SHCC may make the organizational and related changes required and act in accordance with the changes in their functions at any time. Changes in certificate of need requirements become effective 180 days after enactment except when a change in law is required in which case a longer period is allowed (section 127).

The conference substitute conforms to the House amendment (section 129).

The conferees note that the changes in the HSA funding provisions are not effective until the Congress has adopted an appropriation for fiscal year 1980.

employees against a worsening of their positions respecting employment. This means that the hospitals should make a reasonable effort to obtain comparable employment for affected employees and should substantially preserve the rights achieved by the employees. The Secretary of Labor should describe the issues which hospitals must address in making fair and equitable arrangements, and is expected to actively encourage and foster adequate protection for all employees affected by grants under this section.

Grants to States for reduction of excess hospital capacity

The Senate bill authorizes the Secretary to make grants to SHPDA's for planning, evaluating or carrying out programs to decertify health care facilities (section 205).

The House amendment contains a provision which authorizes grants to States for the purpose of demonstrating the effectiveness of various means of reducing excess hospital capacity. Such grants would assist SHPDA's in identifying excess capacity, informing the public of its costs, and developing a program to reduce excess capacity in a way that provides the greatest savings in the cost of health care delivery. Four million dollars is authorized for each of the next three years (section 118(b)).

The conference substitute combines the two approaches in new section 1643. Support for SHPDA's under this section would be limited to 10 percent of the amount appropriated under new section 1644 (section 301).

HARLEY O. STAGGERS,
HENRY A. WAXMAN,
DAVID E. SATTERFIELD,
RICHARDSON PREYER,
JAMES T. BROYHILL,
TIM LEE CARTER,
Managers on the Part of the House.

EDWARD M. KENNEDY,
HARRISON A. WILLIAMS, Jr.,
GAYLORD NELSON,
ALAN CRANSTON,
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RICHARD S. SCHWEIKER,
JACOB K. JAVITS,
ORRIN G. HATCH,
Managers on the Part of the Senate.

○

Calendar No. 98

96TH CONGRESS
1st Session

SENATE

REPORT
No. 96–96

HEALTH PLANNING AMENDMENTS OF 1979

APRIL 26 (legislative day, APRIL 9), 1979.—Ordered to be printed

Mr. KENNEDY, from the Committee on Labor and Human Resources, submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany S. 544]

The Committee on Labor and Human Resources, to which was referred the bill (S. 544) to amend titles XV and XVI of the Public Health Service Act to revise and extend the authorities and requirements under those titles for health planning and health resources development, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

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The certificate-of-need programs vary with each State, consistent with Federal requirements, although all must include requirements for approval of any new construction or significant capital expenditure. The certificate-of-need provisions of Public Law 93–641 were designed to improve upon the capital expenditure review provision (section 1122) of Public Law 92–603, the Social Security Amendments of 1972, which encouraged States to participate in capital expenditures review programs. In enacting the section 1122 program, Congress wanted to make certain that reimbursement for depreciation on buildings and equipment, and interest on loans used to acquire them, (items which are considered reimbursable as part of the cost of providing services under the Medicare, medicaid, and maternal and Child Health programs), would be made in line with the then-designated planning agency's approvals. When all States have effective certificate-of-need programs (which are generally more comprehensive than the section 1122 controls), many feel there will be no further need for the section 1122 capital expenditures review program.

The Department issued regulations specifying the minimum requirements for satisfactory State certificate-of-need programs on January 21, 1977. (These regulations were strengthened by revisions published in the Federal Register on April 8, 1977). These Federal certificate-of-need regulations, in setting forth the minimum requirements for State certificate-of-need programs, drew upon the experience of the States and the Department in administering previous certificate-of-need and section 1122 programs, so that the weaknesses of these earlier programs would be overcome.

The Department now requires that State health planning and development agencies administer satisfactory certificate-of-need programs in order to become fully designated and thus to participate fully in the programs authorized by titles XV and XVI of the Public Health Service Act.[2] The HEW regional offices have the primary responsibility for providing assistance to the States in the development of satisfactory certificate-of-need programs, and they have been delegated the authority to approve or disapprove the certificate-of-need programs of each State.

The law mandates States to establish State certificate-of-need programs, satisfactory to the Secretary of HEW, which would apply to new institutional health services proposed to be offered or developed within the State. The CON program is to be administered by the State agency and is to contain sanctions (e.g., denial or revocation of licensure, civil or criminal penalties) so that only those services, facilities, and organizations found to be needed will actually be offered or developed in the State. Regulations spell out the types of new institutional health services which are subject to certificate-of-need review and the definition of a "health care facility" through, by, or on behalf of which such services would be made available.

[2] It is important to note that what is required of SHPDAs is that they *administer* a satisfactory certificate-of-need program, not that they enact a statute or develop a regulation. The SHPDA must secure whatever combination of authorities (statutory, regulatory, Attorney General opinions, and so forth) that may be necessary to administer a program meeting minimum Federal requirements. Further, State certificate-of-need programs may be more stringent or more comprehensive than the minimum Federal certificate of need standards.

BEST DOCUMENT AVAILABLE

XII. MINORITY VIEWS OF SENATOR GORDON HUMPHREY

The Health Planning Act has been an unmitigated disaster for my State of New Hampshire. Our one health systems agency has antagonized our entire health care community for several years with an arrogant attitude of federal rectitude. Everywhere I have gone in the state I have heard complaints concerning the officious presumption of this agency. Large sums have been wasted in needless litigation more money has been lost through the lengthy delays of projects that were ultimately undertaken. Planning itself has been given a bad name. Recently, the more objectionable functionaries of this agency were replaced, hopefully, by people more mindful of democracy and liberty; but what happened in New Hampshire was no peculiar aberration. It was a logical consequence of the federal paternalism that permeates the thinking of too many bureaucrats and politicians.

Proponents of the Health Planning Act claim that it has saved billions of dollars, but I am skeptical of their figures. They maintain that the act has saved $8 for ever $1 invested in it. This ratio is derived by totaling the estimated costs of all projects rejected by the planning agencies, and comparing that figure to the administrative costs of these agencies. This method is deficient in a number of ways. It does not include the costs to the health providers of preparing, and defending plans before the agencies. It does not include the costs of delay while a plan is mired in the bureaucratic morass. It presumes that every dollar listed in a rejected proposal would have been raised and spent. Clearly, the Health Planning Act has not appreciably reduced the inflation of hospital costs, nor has it forestalled the avid desire of some people for a further extension of bureaucratic control in the form of mandatory price ceilings for hospitals.

The complexity of modern health care requires the rationalization of health services. Toward this end, health planning is a worthy endeavor, but this planning can and should be locally inspired. The Health Planning Act complicates local affairs, arrogates local responsibilities, and fails as a major means of hospital cost containment. Health care services are usually small scale, community based enterprises. Their coordination would best be effected by informal arrangements among them and the attention of local government. Federal forms, federal reports, and federal overseers are an onerous officiousness which is unwarranted and unwise.

96TH CONGRESS
1st Session

SENATE

REPORT
No. 96-309

HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1979

AUGUST 9, 1979.—Ordered to be printed

Filed under authority of the order of the Senate of August 3 (legislative day, June 21), 1979

Mr. KENNEDY, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany S. 544]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 544) to amend titles XV and XVI of the Public Health Service Act to revise and extend the authorities and requirements under those titles for health planning and health resources development, having met, after full and free confererence, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

SHORT TITLE; REFERENCES TO PUBLIC HEALTH SERVICE ACT; AND TABLE OF CONTENTS

SECTION 1. (a) This Act may be cited as the "Health Planning and Resources Development Amendments of 1979".

(b) Whenever in this Act (other than in subsections (j) and (k) of section 115 and subsection (a) of section 128) an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

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Sec. 120. Coordination of health planning with rate review.
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Sec. 124. Statewide Health Coordinating Council composition.
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Sec. 127. Authorizations.
Sec. 128. Technical amendment.
Sec. 129. Effective date.

TITLE II—REVISION OF AUTHORITY FOR HEALTH RESOURCES DEVELOPMENT

Sec. 201. Revision and extension of assistance.
Sec. 202. Conforming amendments.
Sec. 203. Technical amendments.
Sec. 204. Effective date.

TITLE III—PROGRAM TO ASSIST AND ENCOURAGE THE DISCONTINUANCE OF UNNEEDED HOSPITAL SERVICES

Sec. 301. Authorization of program.
Sec. 302. Study.

TITLE I—REVISION OF HEALTH PLANNING AUTHORITY

REVISION AND REPORTING ON NATIONAL GUIDELINES FOR HEALTH PLANNING

SEC. 101. (a)(1)(A) Section 1501 is amended (i) by striking out "and shall, as he deems appropriate, by regulation revise such guidelines" in subsection (a), and (ii) by adding after subsection (c) the following:

$45,000,000 for fiscal year 1981, and $50,000,000 for fiscal year 1982 (section 139).

The House amendment provides for authorizations of appropriations for State agencies at a level of $35,000,000 for fiscal year 1980, $37,000,000 for fiscal year 1981, and $39,000,000 for fiscal year 1982 (section 124(b)).

The conference substitute as a compromise specifies authorizations of appropriations of $35,000,000 for fiscal year 1980, $40,000,000 for fiscal year 1981, and $45,000,000 for fiscal year 1982 (section 127(b)).

Rate review authorizations

The Senate bill provides authorizations of appropriations for rate setting under section 1626(e) of $6,000,000 for fiscal year 1980, $6,000,000 for fiscal year 1981 and $6,000,000 for fiscal year 1982 (section 140).

The House bill provides authorization of appropriations for rate review of $6,000,000 for fiscal year 1980, $7,000,000 for fiscal year 1981, and $8,000,000 for fiscal year 1982 (section 126(e)).

The conference substitute conforms to the Senate bill (section 127(c)).

Centers for health planning

The Senate bill provides authorizations of appropriations for centers for health planning and technical assistance of $6,000,000 for fiscal year 1980, $8,000,000 for fiscal year 1981 and $10,000,000 for fiscal year 1982 (section 149).

The House amendment provides authorizations of appropriations for carrying out section 1534 of $10,000,000 for fiscal year 1980, $11,000,000 for fiscal year 1981, and $12,000,000 for fiscal year 1982 (section 125(d)).

The conference substitute as a compromise specifies authorizations of appropriations for the support of activities under section 1534 $6,000,000 for fiscal year 1980, $8,000,000 for fiscal year 1981, and $10,000,000 for fiscal year 1982 (section 127(d)).

Area health services development fund

The Senate bill contains no authorizations of appropriations for the area health services development funds.

The House amendment contains authorizations of appropriations for the same purpose at a level of $25,000,000 for fiscal year 1980, $40,000,000 for fiscal year 1981, and $50,000,000 for fiscal year 1982 (section 125).

The conference substitute as a compromise provides $20,000,000 for fiscal year 1981 and $30,000,000 in fiscal year 1982 (section 127(e)).

TECHNICAL AMENDMENT

Percentage of HMO enrollees

The House amendment contains a provision amending section 1903(m)(2)(c) of the Social Security Act to allow a health maintenance organization three years from the time it is qualified to meet the requirement that at least 50 percent of an HMO's enrolled

population be made up of other than Medicare and Medicaid recipients (section 126).

The conference substitute conforms to the House amendment (section 128).

Miscellaneous amendments

The Senate bill contains a provision, not included in the House amendment, which repeals section 314 (a) (b) and (c) and Title 9 in its entirety.

The conference substitute conforms to the Senate bill.

Report on effectiveness of planning law

The House amendment contains a provision, not included in the Senate bill, which specifies that the Secretary shall report to the Congress on the results of the review conducted pursuant to Section 1535 respecting improvements in health and health care and restraints on increases in health care costs (section 125).

The conference substitute conforms to the Senate bill.

EFFECTIVE DATES

The Senate bill provides that amendments to Title XV shall take effect on the date of enactment of this Act, except that certain amendments shall take effect one year from the date of enactment and other amendments shall take effect six months from the date of enactment except that on or after the date of enactment, the HSA's, the State Agencies, and the SHCC's, may make the organizational and related changes required and may act in accordance with the changes in their functions made by such amendments (section 157).

The House amendments provides that certain amendments shall take effect one year after the date of enactment except that on or after the date of enactment, the changes in membership of the HSA's, and the SHPDA's shall be implemented through selection of members to fill vacancies occurring after such date, except that the HSA, the State Agency and the SHCC may make the organizational and related changes required and act in accordance with the changes in their functions at any time. Changes in certificate of need requirements become effective 180 days after enactment except when a change in law is required in which case a longer period is allowed (section 127).

The conference substitute conforms to the House amendment (section 129).

The conferees note that the changes in the HSA funding provisions are not effective until the Congress has adopted an appropriation for fiscal year 1980.

EDWARD KENNEDY,
HARRISON A. WILLIAMS, Jr.,
GAYLORD NELSON,
ALAN CRANSTON,
C. PELL,
RICHARD S. SCHWEIKER,
J. JAVITS,
ORRIN G. HATCH,
Managers on the Part of the Senate.

HARLEY O. STAGGERS,
HENRY A. WAXMAN,
DAVID SATTERFIELD,
RICHARDSON PREYER,
JAMES T. BROYHILL,
TIM LEE CARTER,
Managers on the Part of the House.

O

Finder's Aid

P.L. 96-178 (93 Stat. 1295) Approved January 2, 1980

Subject	SS Act Section	P.L. Section	93 Stat.	H.Rep.* 96-63	H.C.Rep. 96-718	**
Child Support Enforcement	455(a)	2(a)	1295		7	
Funding for Child Day Care Services	2002(a)(1)	4(a)	1296		7-8	
Renumbering Existing Section (Technical)	2008	4(b)	1296		3, 7-8	
Authority to Hire Welfare Recipients as Child Care Workers	2007	4(b)	1296		7-8	
Technical Amendment	2002(a)(4)(C)	4(c)	1297		4, 7-8	
Technical Amendment	2002(a)(4)(D)	4(c)	1297		4, 7-8	
Technical Amendment	2002(a)(5)(A)	4(c)	1297		4, 7-8	

* Deals only with business expenses of State Legislators.
** No Senate Reports.

BEST DOCUMENT AVAILABLE

Public Law 96-178
96th Congress

An Act

To extend for one year the provisions of law relating to the business expenses of State legislators.

Jan. 2, 1980
[H.R. 3091]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That subsections (a) and (d) of section 604 of the Tax Reform Act of 1976 (Public Law 94-455) are each amended by striking out "January 1, 1978" and inserting in lieu thereof "January 1, 1979".

State legislators' business expenses, provisions of law, extension.
26 USC 162 note.

CHILD SUPPORT ENFORCEMENT

SEC. 2. (a) Section 455(a) of the Social Security Act is amended— 42 USC 655.

(1) by striking out the semicolon at the end of paragraph (2) and inserting in lieu of such semicolon a period, and

(2) by striking out all that follows paragraph (2).

(b) This section shall become effective on the date of the enactment of this Act, and shall apply with respect to services furnished during the period beginning October 1, 1978, and ending March 31, 1980.

Effective date.
42 USC 655 note.

WIN CREDIT

SEC. 3. (a)(1) Section 50B of the Internal Revenue Code of 1954 is amended by redesignating subsection (i) as subsection (j) and by adding after subsection (h) the following new subsection: 26 USC 50B.

"(i) SPECIAL RULES WITH RESPECT TO EMPLOYMENT OF DAY CARE WORKERS.—

"(1) ELIGIBLE EMPLOYEE.—An individual who would be an 'eligible employee' (as that term is defined for purposes of this section) except for the fact that such individual's employment is not on a substantially full-time basis, shall be deemed to be an eligible employee as so defined, if such employee's employment consists of services performed in connection with a child day care program of the taxpayer, on either a full-time or part-time basis.

"(2) ALTERNATIVE LIMITATION WITH RESPECT TO CHILD DAY CARE SERVICES ELIGIBLE EMPLOYEES.—The amount of the credit allowed a taxpayer under the preceding provisions of this section with respect to work incentive program expenses paid or incurred by him with respect to an eligible employee whose services are performed in connection with a child day care services program conducted by the taxpayer shall, at the election of the taxpayer, be determined by including (in computing the amount of such expenses so paid or incurred by him) any amount with respect to such employee for which he was reimbursed from funds made available pursuant to section 3(c) of Public Law 94-401 or section 2007 of title XX of the Social Security Act, except that, if the total amount of such credit, as so computed, plus such amount reimbursed to him under such sections, exceeds the lesser of $6,000 or 100 percent of the total expenses paid or incurred by him with respect to such employee, the amount of such credit shall be

42 USC 1397a note.
42 USC 1397f.

reduced (but not below zero) so as to provide that such total does not exceed the lesser of $6,000 or 100 percent of the total expenses paid or incurred by him with respect to such employee.".

Effective date. 26 USC 50B note.

(2) The amendment made by paragraph (1) shall become effective on the date of the enactment of this Act, and shall apply with respect to taxable years beginning after December 31, 1978, and before January 1, 1980.

26 USC 50B. 92 Stat. 2763.

(3) Section 50B(a)(2)(B) of the Internal Revenue Code of 1954 as in effect prior to amendment by the Revenue Act of 1978 is amended, effective October 1, 1978, by striking out "October 1, 1978" and inserting in lieu thereof "January 1, 1979".

42 USC 1397a note.

(b) Paragraphs (1) and (2)(A) of section 3(c) of Public Law 94-401 are each amended by striking out "(other than the fiscal year ending September 30, 1979)".

(c) Paragraphs (1) and (3)(B) of section 3(c) of Public Law 94-401 are each amended by striking out "Federal welfare recipient employment incentive expenses" each time it appears and inserting in lieu thereof in each instance "work incentive program expenses".

(d) Section 3(c)(3)(B) of Public Law 94-401 is amended—

(1) by striking out "Federal welfare recipient employment expenses" and inserting in lieu thereof "work incentive program expenses"; and

(2) by striking out "section 50B(a)(2)" and inserting in lieu thereof "section 50B(a)(1)".

(e) Section 3(c)(2)(B) of Public Law 94-401 is amended—

(1) by striking out "$5,000" and inserting in lieu thereof "$6,000"; and

(2) by striking out "$4,000" and inserting in lieu thereof "$5,000".

Effective date. 42 USC 1397a note.

(f)(1) The amendments made by subsection (b) shall become effective on the date of the enactment of this Act, and shall apply with respect to grants made to qualified providers of child day care services on or after October 1, 1978.

(2) The amendments made by subsections (c), (d), and (e) shall become effective on the date of the enactment of this Act, and shall apply with respect to expenses paid or incurred after December 31, 1978.

CHILD DAY CARE SERVICES

42 USC 1397a.

SEC. 4. (a) Section 2002(a)(1) of the Social Security Act is amended by inserting "100 per centum of the expenditures during that quarter (which are not in excess of 2 per centum of the limitation applicable to that State under paragraph (2)(A) for the fiscal year in which such quarter occurs) for grants to qualified providers under section 2007," after "an amount equal to".

42 USC 1397f.

(b) Title XX of such Act is amended by redesignating section 2007 as section 2008 and inserting after section 2006 the following new section:

"CHILD DAY CARE SERVICES

42 USC 1397e-1.

"SEC. 2007. (a) Subject to subsection (b), sums granted by a State to a qualified provider of child day care services (as defined in subsection (c)) to assist such provider in meeting its work incentive program expenses (as defined in subsection (c)) with respect to individuals employed in jobs related to the provision of child day care services in one or more child day care facilities of such provider, shall be deemed for purposes of section 2002 to constitute expenditures made by the

State in accordance with the provisions of this title for the provision of child day care services.

"(b) The provisions of subsection (a) shall not be applicable with respect to any grant made to a particular qualified provider of child day care services to the extent that (as determined by the Secretary) such grant is or will be used to pay wages to any employee at an annual rate in excess of $6,000, in the case of a public or nonprofit private provider, or at an annual rate in excess of $5,000, or to pay more than 80 per centum of the wages of any employee, in the case of any other provider.

"(c) For purposes of this subsection— Definitions.

"(1) the term 'qualified provider of child day care services', when used in reference to a recipient of a grant by a State, includes a provider of such services only if, of the total number of children receiving such services from such provider in the facility with respect to which the grant is made, at least 20 per centum thereof have some or all of the costs for the child day care services so furnished to them by such provider paid for under the State's services program conducted pursuant to this title; and

"(2) the term 'work incentive program expenses' means expenses of a qualified provider of child day care services which constitute work incentive program expenses as defined in section 50B(a)(1) of the Internal Revenue Code of 1954, or which would constitute work incentive program expenses as so defined if the provider were a taxpayer entitled to a credit (with respect to the wages involved) under section 40 of such Code.". 26 USC 50B. 26 USC 40.

(c) Sections 2002(a)(4)(C), 2002(a)(4)(D), and 2002(a)(5)(A) of such Act are each amended by striking out "2007(1)" and inserting in lieu thereof "2008(1)". 42 USC 1397a.

(d) The amendments made by this section shall become effective on the date of the enactment of this Act, and shall apply with respect to grants made to qualified providers of child day care services during the period beginning October 1, 1979, and ending March 31, 1980. Effective date. 42 USC 1397e-1 note.

EXTENSION OF PROVISIONS RELATING TO ALCOHOLICS AND DRUG ADDICTS

SEC. 5. (a) Section 4(c) of Public Law 94-120 is amended by striking out "only for the period" and all that follows and inserting in lieu thereof "from and after October 1, 1975.". 42 USC 1397a note.

(b) The amendment made by subsection (a) shall become effective on the date of the enactment of this Act, and shall apply with respect to services provided during the period beginning October 1, 1978, and ending March 31, 1980. Effective date. 42 USC 1397a note.

AMENDMENTS RELATED TO SECTION 322 OF THE REVENUE ACT OF 1978

SEC. 6. (a) Paragraph (1) of section 322(e) of the Revenue Act of 1978 (relating to effective date) is amended by adding at the end thereof the following new sentence: "For purposes of applying section 50A(a)(2) of the Internal Revenue Code of 1954 with respect to a taxable year beginning before January 1, 1979, the rules of sections 50A(a)(4), 50A(a)(5), and 50B(e)(3) of such Code (as in effect on the day before the date of the enactment of this Act shall apply.". 92 Stat. 2836. 26 USC 50A note. 26 USC 50A. 26 USC 50B.

(b) Subparagraph (B) of section 322(e)(2) of the Revenue Act of 1978 (relating to eligible employees hired after September 26, 1978) is amended—

(1) by striking out "September 27, 1978," and inserting in lieu thereof "September 26, 1978, for purposes of applying the amendments made by this section,"; and

(2) by striking out "January 1, 1979." and inserting in lieu thereof "January 1, 1979, and any wages paid or incurred after December 31, 1978, with respect to such individual shall be considered to be attributable to services rendered after that date.".

26 USC 50A. (c)(1) Subparagraph (C) of section 50A(a)(4) of the Internal Revenue Code of 1954 (relating to limitation with respect to nonbusiness eligible employees) is amended by striking out "'$6,000' and" and inserting in lieu thereof "'$6,000' for".

26 USC 50B. (2) Subparagraph (B) of section 50B(g)(2) of such Code is amended by striking out "giving to such credit" and inserting in lieu thereof "giving rise to such credit".

(3) Clause (i) of section 50B(h)(1)(A) of such Code is amended by striking out "9-day" and inserting in lieu thereof "90-day".

92 Stat. 2836. 26 USC 280C. (4) The second subsection designated as subsection (d) of section 322 of the Revenue Act of 1978 is amended by striking out "our" in paragraph (1)(A) thereof and inserting in lieu thereof "out".

Effective date. 26 USC 50A note. (d) Any amendment made by this section to the Revenue Act of 1978 shall take effect as if it had been included in the provision of the Revenue Act of 1978 to which such amendment relates.

Effective date.

Approved January 2, 1980.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 96-63 (Comm. on Ways and Means) and No. 96-718 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 125 (1979):

Mar. 27, considered and passed House.

Mar. 28, considered and passed Senate, amended.

Dec. 19, House agreed to conference report.

Dec. 20, Senate agreed to conference report.

○

House Report 96-63 deals only with business expenses of State Legislators.

96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 96–718

BUSINESS EXPENSES OF STATE LEGISLATORS; SOCIAL SERVICES AND RELATED AMENDMENTS

DECEMBER 19, 1979.—Ordered to be printed

Mr. ULLMAN, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 3091]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3091) to extend for 1 year the provisions of law related to the business expenses of State legislators, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

CHILD SUPPORT ENFORCEMENT

SEC. 2. (a) Section 45 (a) of the Social Security Act is amended—

(1) by striking out the semicolon at the end of paragraph (2) and inserting in lieu of such semicolon a period, and

(2) by striking out all that follows paragraph (2).

(b) This section shall become effective on the date of the enactment of this Act, and shall apply with respect to services furnished during the period beginning October 1, 1978, and ending March 31, 1980.

WIN CREDIT

SEC. 3. (a)(1) Section 50B of the Internal Revenue Code of 1954 is amended by redesignating subsection (i) as subsection (j) and by adding after subsection (h) the following new subsection:

"(i) SPECIAL RULES WITH RESPECT TO EMPLOYMENT OF DAY CARE WORKERS.—

"(1) ELIGIBLE EMPLOYEE.—An individual who would be an 'eligible employee' (as that term is defined for purposes of this sec-

tion) except for the fact that such individual's employment is not on a substantially full-time basis, shall be deemed to be an eligible employee as so defined, if such employee's employment consists of services performed in connection with a child day care program of the taxpayer, on either a full-time or part-time basis.

"(2) ALTERNATIVE LIMITATION WITH RESPECT TO CHILD DAY CARE SERVICES ELIGIBLE EMPLOYEES.—The amount of the credit allowed a taxpayer under the preceding provisions of this section with respect to work incentive program expenses paid or incurred by him with respect to an eligible employee whose services are performed in connection with a child day care services program conducted by the taxpayer shall, at the election of the taxpayer, be determined by including (in computing the amount of such expenses so paid or incurred by him) any amount with respect to such employee for which he was reimbursed from funds made available pursuant to section 3(c) of Public Law 94–401 or section 2007 of title XX of the Social Security Act, except that, if the total amount of such credit, as so computed, plus such amount reimbursed to him under such sections, exceed the lesser of $6,000 or 100 percent of the total expenses paid or incurred by him with respect to such employee, the amount of such credit shall be reduced (but not below zero) so as to provide that such total does not exceed the lesser of $6,000 or 100 percent of the total expenses paid or incurred by him with respect to such employee.".

(2) The amendment made by paragraph (1) shall become effective on the date of the enactment of this Act, and shall apply with respect to taxable years beginning after December 31, 1978, and before January 1, 1980.

(3) Section 50B(a)(2)(B) of the Internal Revenue Code of 1954 as in effect prior to amendment by the Revenue Act of 1978 is amended, effective October 1, 1978, by striking out "October 1, 1978" and inserting in lieu thereof "January 1, 1979".

(b) Paragraphs (1) and (2)(A) of section 3(c) of Public Law 94–401 are each amended by striking out "(other than the fiscal year ending September 30, 1979)".

(c) Paragraphs (1) and (3)(B) of section 3(c) of Public Law 94–401 are each amended by striking out "Federal welfare recipient employment incentive expenses" each time it appears and inserting in lieu thereof in each instance "work incentive program expenses".

(d) Section 3(c)(3)(B) of Public Law 94–401 is amended—

(1) by striking out "Federal welfare recipient employment expenses" and inserting in lieu thereof "work incentive program expenses"; and

(2) by striking out "section 50B(a)(2)" and inserting in lieu thereof "section 50B(a)(1)".

(e) Section 3(c)(2)(B) of Public Law 94–401 is amended—

(1) by striking out "$5,000" and inserting in lieu thereof "$6,000"; and

(2) by striking out "$4,000" and inserting in lieu thereof "$5,000".

(f)(1) The amendments made by subsection (b) shall become effective on the date of the enactment of this Act, and shall apply with respect to grants made to qualified providers of child day care services on or after October 1, 1978.

(2) The amendments made by subsections (c), (d), and (e) shall become effective on the date of the enactment of this Act, and shall apply with respect to expenses paid or incurred after December 31, 1978.

CHILD DAY CARE SERVICES

SEC. 4. (a) Section 2002(a)(1) of the Social Security Act is amended by inserting "100 per centum of the expenditures during that quarter (which are not in excess of 2 per centum of the limitation applicable to the State under paragraph (2)(A) for the fiscal year in which such quarter occurs) for grants to qualified providers under section 2007," after "an amount equal to".

(b) Title XX of such Act is amended by redesignating section 2007 as section 2008 and inserting after section 2006 the following new section:

"CHILD DAY CARE SERVICES

"SEC. 2007. (a) Subject to subsection (b), sums granted by a State to a qualified provider of child day care services (as defined in subsection (c)) to assist such provider in meeting its work incentive program expenses (as defined in subsection (c)) with respect to individuals employed in jobs related to the provision of child day care services in one or more child day care facilities of such provider, shall be deemed for purposes of section 2002 to constitute expenditures made by the State in accordance with the provisions of this title for the provision of child day care services.

"(b) The provisions of subsection (a) shall not be applicable with respect to any grant made to a particular qualified provider of child day care services to the extent that (as determined by the Secretary) such grant is or will be used to pay wages to any employee at an annual rate in excess of $6,000, in the case of a public or nonprofit private provider or at an annual rate in excess of $5,000, or to pay more than 80 per centum of the wages of any employee, in the case of any other provider.

"(c) For purposes of this subsection—

"(1) the term 'qualified provider of child day care services,' when used in reference to a recipient of a grant by a State, includes a provider of such services only if, of the total number of children receiving such services from such provider in the facility with respect to which the grant is made, at least 20 per centum thereof have some or all of the costs for the child day care services so furnished to them by such provider paid for under the State's services program conducted pursuant to this title; and

"(2) the term 'work incentive program expenses' means expenses of a qualified provider of child day care services which consititute work incentive program expenses as defined in section 50B(a)(1) of the Internal Revenue Code of 1954, or which would constitute work incentive program expenses as so defined if the

provider were a taxpayer entitled to a credit (with respect to the wages involved) under section 40 of such Code.".

(c) Section 2002 (a)(4)(C), 2002(a)(4)(D), and 2002(a)(5)(A) of such Act are each amended by striking out "2007(1)" and inserting in lieu thereof "2008(1)".

(d) The amendments made by this section shall become effective on the date of the enactment of this Act, and shall apply with respect to grants made to qualified providers of child day care services during the period beginning October 1, 1979, and ending March 31, 1980.

EXTENSION OF PROVISIONS RELATING TO ALCOHOLICS AND DRUG ADDICTS

SEC. 5. (a) Section 4(c) of Public Law 94-120 is amended by striking out "only for the period" and all that follows and inserting in lieu thereof "from and after October 1, 1975.".

(b) The amendment made by subsection (a) shall become effective on the date of the enactment of this Act, and shall apply with respect to services provided during the period beginning October 1, 1978, and ending March 31, 1980.

AMENDMENTS RELATED TO SECTION 322 OF THE REVENUE ACT OF 1978

SEC. 6. (a) Paragraph (1) of section 322(e) of the Revenue Act of 1978 (relating to effective date) is amended by adding at the end thereof the following new sentence: "For purposes of applying section 50A(a)(2) of the Internal Revenue Code of 1954 with respect to a taxable year beginning before January 1, 1979, the rules of sections 50A(a)(4), 50A(a)(5), and 50B(e)(3) of such Code (as in effect on the day before the date of the enactment of this Act shall apply.".

(b) Subparagraph (B) of section 322(e)(2) of the Revenue Act of 1978 (relating to eligible employees hired after September 26, 1978) is amended—

(1) by striking out "September 27, 1978." and inserting in lieu thereof "September 26, 1978, for purposes of applying the amendments made by this section."; and

(2) by striking out "January 1, 1979." and inserting in lieu thereof "January 1, 1979, and any wages paid or incurred after December 31, 1978, with respect to such individual shall be considered to be attributable to services rendered after that date.".

(c)(1) Subparagraph (C) of section 50A(a)(4) of the Internal Revenue Code of 1954 (relating to limitation with respect to nonbusiness eligible employees) is amended by striking out "'$6,000' and" and inserting in lieu thereof "'$6,000' for".

(2) Subparagraph (B) of section 50B(g)(2) of such Code is amended by striking out "giving to such credit" and inserting in lieu thereof "giving rise to such credit".

(3) Clause (i) of section 50B(h)(1)(A) of such Code is amended by striking out "9-day" and inserting in lieu thereof "90-day".

(4) The second subsection designated as subsection (d) of section 322 of the Revenue Act of 1978 is amended by striking out "our" in paragraph (1)(A) thereof and inserting in lieu thereof "out".

(d) Any amendment made by this section to the Revenue Act of 1978 shall take effect as if it had been included in the provision of the Revenue Act of 1978 to which such amendment relates.

And the Senate agree to the same.

AL ULLMAN,
DAN ROSTENKOWSKI,
JAMES C. CORMAN,
CHARLES B. RANGEL,
BARBER CONABLE,
JOHN H. ROUSSELOT,
Managers on the Part of the House.

RUSSELL B. LONG,
H. E. TALMADGE,
DANIEL MOYNIHAN,
DAVID L. BOREN,
BOB DOLE,
BOB PACKWOOD,
Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3091) to extend for one year the provisions of law relating to the business expenses of State legislators, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

1. BUSINESS EXPENSES OF STATE LEGISLATORS

Both the House and Senate versions contain a provision extending for one year the provisions of law relating to the business expenses of State legislators.

2. CHILD SUPPORT ENFORCEMENT FOR NON-AFDC FAMILIES

House bill.—No provision.

Senate amendment.—The Child Support Enforcement Program requires States to make available services to both AFDC and non-AFDC families to assist in establishing the paternity of children and in securing support from absent parents. The original legislation enacted in 1975 provided for 75 percent Federal matching of the costs incurred by the States in providing these services. In the case of AFDC families, the Federal matching provision was enacted in 1975 on a permanent basis while the matching for services to non-AFDC families was provided only through June 30, 1976. Congress subsequently extended the provision for Federal matching for services to non-AFDC families through fiscal year 1977, and fiscal year 1978.

The Senate amendment would make permanent the authority for 75 percent Federal matching of State costs in providing child support services to families not eligible for AFDC. This authority would be retroactive to October 1, 1978.

Conference Agreement.—The Conference agreement follows the Senate amendment, except the authority for Federal matching funds would be effective only for the period October 1, 1978 through March 31, 1980.

3. PROVISIONS RELATING TO AUTHORITY TO HIRE WELFARE RECIPIENTS AS CHILD CARE WORKERS

House bill.—No provision.

Senate amendment.—The amendment would restore the authority of the States to use social services funds under title XX to pay the costs of employing welfare recipients in child care jobs. This authority was available in fiscal years 1977 and 1978. The amendment would make

this authority permanent, retroactive to October 1, 1978. It would also make certain changes to conform and better coordinate it with the provisions under which employers obtain a tax credit for hiring welfare recipients. Specifically, the amendment would—

1. extend the authority to use title XX funds to reimburse the costs of hiring welfare recipients in child care jobs;

2. incorporate this authority as a permanent part of the basic title XX statute;

3. increase the maximum per recipient annual combined tax credit and title XX reimbursement from $5,000 to $6,000—the same level of wages that is eligible for the new welfare recipient tax credit;

4. make the payment and credit available for part-time as well as full-time employment in child care jobs;

5. permit the credit to be computed on the basis of the full wages including the part reimbursed under title XX—subject to a maximum combined tax credit and title XX payment not to exceed 100 percent of the first $6,000 of wages; and

6. make the tax credit coverage applicable to the period between the date it previously expired (October 1, 1978) and the effective date of the new credit enacted last year (January 1, 1979).

Conference Agreement.—The Conference agreement follows the Senate amendment, except the authority to use title XX funds to make grants to qualified child day care providers would be effective only for the period October 1, 1978 through March 31, 1980, and the tax credit for hiring welfare recipients would apply only with respect to taxable years beginning after December 31, 1978 and before January 1, 1980.

4. TITLE XX SERVICES TO ALCOHOLICS AND DRUG ADDICTS

House bill.—No provision.

Senate amendment.—The Senate amendment reinstates and makes permanent, retroactive to October 1, 1978, temporary provisions of law relating to the use of title XX funds for certain services to alcoholics and drug addicts. These temporary provisions expired September 30, 1978. Title XX funds ordinarily may only be used to provide health services if the services are an integral, but subordinate, part of a social service. The law provides also that funds may not be used for services to persons in medical institutions. The amendment would make permanent those expired provisions of law which permitted consideration of the entire rehabilitative process in determining whether medical services provided to addicts and alcoholics are an integral but subordinate part of a social service. Also made permanent would be provisions allowing funding for up to 7 days of detoxification services provided to alcoholics and drug addicts in medical institutions, and provisions applying the privacy protections of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

Conference Agreement.—The Conference agreement follows the Senate amendment, except the authority for the title XX matching funds would be available only for the period October 1, 1978 through March 31, 1980.

AL ULLMAN,
DAN ROSTENKOSKI,
JAMES C. CORMAN,
CHARLES B. RANGEL,
BARBER CONABLE,
JOHN H. ROUSSELOT,
Managers on the Part of the House.

RUSSELL B. LONG,
H. E. TALMADGE,
DANIEL MOYNIHAN,
DAVID L. BOREN,
BOB DOLE,
BOB PACKWOOD,
Managers on the Part of the Senate.

Finder's Aid

P.L. 96-222 (94 Stat. 194) Approved April 1, 1980
Technical Corrections Act of 1979

Subject	SS Act Section	P.L. Section	94 Stat.	H.Rep. 96-250	S.Rep. 96-498
Payments Treated as Earned Income for AFDC	402(d)	101(a)(2)(A)	195	12-13	12-13
Payments Treated as Earned Income for SSI	1612(a)(1)(A), (C)	101(a)(2)(B)	195	12-13	12-13
Treatment of Excess Payments Under SSI	1631(b)(1), (2)	101(a)(2)(C)	195	13	13

BEST DOCUMENT AVAILABLE

TECHNICAL CORRECTIONS ACT OF 1979

Public Law 96-222
96th Congress

An Act

Apr. 1, 1980
[H.R. 2797]

To make technical corrections related to the Revenue Act of 1978.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Technical Corrections Act of 1979.

SECTION 1. SHORT TITLE, ETC.

26 USC 1 note.

(a) SHORT TITLE.—This Act may be cited as the "Technical Corrections Act of 1979".

(b) AMENDMENT OF 1954 CODE.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1954.

26 USC 1 *et seq.*

26 USC 1 note.

SEC. 2. COORDINATION OF ENACTMENT DATES OF REVENUE ACT OF 1978 AND ENERGY TAX ACT OF 1978.

The Revenue Act of 1978 is amended by inserting after section 3 the following new section:

26 USC 46 note.

"SEC. 4. COORDINATION OF ENACTMENT DATES WITH ENERGY TAX ACT OF 1978.

26 USC 46, 48.
26 USC 1 note.

"For purposes of applying the amendments made by this Act to sections 46 and 48 of the Internal Revenue Code of 1954, the Energy Tax Act of 1978 shall be deemed to have been enacted immediately before this Act."

TITLE I—AMENDMENTS RELATED TO REVENUE ACT OF 1978

SEC. 101. AMENDMENTS RELATED TO TITLE I.

(a) GENERAL RULE.—

26 USC 43.

(1) AMENDMENT RELATED TO SECTION 104 OF THE ACT.—Subparagraph (C) of section 43(c)(1) (relating to individual entitled to exclude income under section 911 not eligible individual) is amended to read as follows:

"(C) INDIVIDUAL WHO CLAIMS BENEFITS OF SECTION 911, 913, OR 931 NOT ELIGIBLE INDIVIDUAL.—The term 'eligible individual' does not include an individual who, for the taxable year, claims the benefits of—

"(i) section 911 (relating to income earned by individuals in certain camps outside the United States),

"(ii) section 913 (relating to deduction for certain expenses of living abroad), or

"(iii) section 931 (relating to income from sources within possessions of the United States)."

(2) AMENDMENTS RELATED TO SECTION 105 OF THE ACT.— 92 Stat. 2773.

(A) PAYMENTS TREATED AS EARNED INCOME FOR AFDC.—Section 402 of the Social Security Act is amended by adding at the end thereof the following new subsection: 42 USC 602.

"(d)(1) For purposes of paragraphs (7) and (8) of subsection (a), any refund of Federal income taxes made by reason of section 43 of the Internal Revenue Code of 1954 (relating to earned income credit) and any payment made by an employer under section 3507 of such Code (relating to advance payment of earned income credit) shall be considered earned income. 26 USC 43.

"(2) In any case in which such advance payments for a taxable year made by all employers to an individual under section 3507 of such Code exceed the amount of such individual's earned income credit allowable under section 43 of such Code for such year, so that such individual is liable under section 43(g) of such Code for a tax equal to such excess, such individual's benefit amount must be appropriately adjusted so as to provide payment to such individual of an amount equal to the amount of the benefits lost by such individual on account of such excess advance payments."

(B) PAYMENT TREATED AS EARNED INCOME FOR SSI.—Section 1612(a)(1) of the Social Security Act is amended— 42 USC 1382a.

(i) by striking out "and" at the end of subparagraph (A); and

(ii) by adding after subparagraph (B) the following new subparagraph:

"(C) any refund of Federal income taxes made by reason of section 43 of the Internal Revenue Code of 1954 (relating to earned income credit) and any payment made by an employer under section 3507 of such Code (relating to advance payment of earned income credit); and". 26 USC 43.

(C) TREATMENT OF EXCESS PAYMENTS UNDER SSI.—Section 1631(b) of the Social Security Act is amended by inserting "(1)" after "(b)" and by adding at the end thereof the following new paragraph: 42 USC 1383.

"(2) In any case in which advance payments for a taxable year made by all employers to an individual under section 3507 of the Internal Revenue Code of 1954 (relating to advance payment of earned income credit) exceed the amount of such individual's earned income credit allowable under section 43 of such Code for such year, so that such individual is liable under section 43(g) of such Code for a tax equal to such excess, the Secretary shall provide for an appropriate adjustment of such individual's benefit amount under this title so as to provide payment to such individual of an amount equal to the amount of such benefits lost by such individual on account of such excess advance payments." 26 USC 3507.

(D) EFFECTIVE DATE FOR ADVANCE PAYMENT OF EARNED INCOME CREDIT.—Paragraph (2) of section 105(g) of the Revenue Act of 1978 (relating to effective date for advance payment of earned income credit) is amended by striking out "June 30, 1978" and inserting in lieu thereof "June 30, 1979". 26 USC 3507 note. 26 USC 43 note.

(E) CLERICAL AMENDMENT.—Subsection (h) of section 43 (relating to coordination with advance payments of earned income credit) is redesignated as subsection (g). 26 USC 43.

(3) AMENDMENT RELATED TO SECTION 112 OF THE ACT.—Paragraph (8) of section 128(a) (relating to cross references) is amended by striking out "benefits, see" and inserting in lieu thereof "benefits which are not includible in gross income under section 85,". 92 Stat. 2777. 26 USC 128.

purchaser on or in connection with an automobile bus, or is to be resold by the purchaser or a second purchaser for such use."

26 USC 48 (6) CLERICAL AMENDMENT.—The last sentence of section 48(a)(10)(B) is amended by striking out "51" and inserting in lieu thereof "5".

26 USC 48 note. (7) EFFECTIVE DATE.—Any amendment made by this subsection shall take effect as if included in the provision of the Energy Tax Act of 1978 to which such amendment relates; except that the amendment made by paragraph (6) shall take effect on the first day of the first calendar month which begins more than 10 days after the date of the enactment of this Act.

26 USC 1 note. *Supra.*

92 Stat. 1332. (d) AMENDMENTS RELATED TO PUBLIC LAW 95-472.—Subsection (c) of section 6324B (relating to special lien for additional estate tax attributable to farm, etc., valuation) is amended to read as follows:

26 USC 6324B. "(c) CERTAIN RULES AND DEFINITIONS MADE APPLICABLE.—

"(1) IN GENERAL.—The rule set forth in paragraphs (1), (3), and (4) of section 6324A(d) shall apply with respect to the lien imposed by this section as if it were a lien imposed by section 6324A.

"(2) QUALIFIED REAL PROPERTY.—For purposes of this section, the term 'qualified real property' includes qualified replacement property (within the meaning of section 2032A(h)(3)(B))."

TITLE II—GENERAL EFFECTIVE DATE

26 USC 43 note. **SEC. 201. GENERAL EFFECTIVE DATE.**

Except as otherwise provided in title I, any amendment made by title I shall take effect as if it had been included in the provision of the 26 USC 1 note. Revenue Act of 1978 to which such amendment relates.

Approved April 1, 1980.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 96-250 (Comm. on Ways and Means).
SENATE REPORT No. 96-498 (Comm. on Finance).
CONGRESSIONAL RECORD:
Vol. 125 (1979): July 16, considered and passed House.
Vol. 126 (1980): Feb. 26, considered and passed Senate, amended.
Feb. 28, House concurred in certain Senate amendments and disagreed to Senate amendment No. 67.
Mar. 18, Senate receded from its amendment No. 67 and offered another amendment to the House bill.
Mar. 19, House concurred in Senate amendment.

96TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
No. 96-250

TECHNICAL CORRECTIONS ACT OF 1979

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ON

H.R. 2797

JUNE 7, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1979

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96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 96-250

TECHNICAL CORRECTIONS ACT OF 1979

JUNE 7, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 2797]

The Committee on Ways and Means, to whom was referred the bill (H.R. 2797) to make technical corrections related to the Revenue Act of 1978, having considered the same, reports favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments are shown in the reported bill, with the matter proposed to be stricken shown in linetype and the matter proposed to be inserted shown in italic type.

I. SUMMARY

In general, the bill contains technical, clerical, conforming, and clarifying amendments to provisions enacted by the Revenue Act of 1978 and other 1978 tax legislation. These amendments were developed as a result of a review of the application of the tax law changes made by 1978 tax legislation, taking into account comments submitted to the committee from the Treasury Department, the Internal Revenue Service, the staff, tax practitioners, and others from the public. In addition to written statements submitted to the committee, the Subcommittee on Select Revenue Measures received public testimony on March 27, 1979, on H.R. 2797, as introduced. The subcommittee approved several amendments on April 25, 1979, and the committee subsequently made further amendments to the bill as a result of the testimony and comments received.

The bill is divided into nine general parts. The first part (sec. 2) coordinates the enactment dates of the Revenue Act of 1978 and the Energy Tax Act of 1978; the next seven parts (secs. 101–107) cover technical, clerical, and conforming amendments to the provisions of the first seven titles of the Revenue Act of 1978 (and the Internal Revenue Code provisions amended thereby); and the last part (sec. 108) covers technical, clerical, and conforming amendments to the Foreign Earned Income Act of 1978, the Black Lung Benefits Revenue Act, and the Energy Tax Act of 1978.

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a. Eligibility for earned income credit for persons claiming section 913 deductions (sec. 101(a)(1) of the bill and sec. 43(c)(1) of the Code)

Present law

Under present law, the earned income credit is not available to taxpayers who are entitled to exclude amounts from income under section 911 (relating to income earned by certain employees in camps) or section 931 (relating to income from sources within the possessions of the United States) for the taxable year. This provision affects only those taxpayers who lived abroad during part of the year since the earned income credit generally is not available to those taxpayers whose principal place of abode for the taxable year is outside the United States.

Reasons for change

The Foreign Earned Income Act of 1978 established a new set of deductions under section 913 of the Code which generally are available to those taxpayers who formerly were entitled to the section 911 exclusion. The committee believes that the credit should continue to be unavailable to the same type of taxpayers who formerly were denied the credit because they qualified for the section 911 exclusion.

Explanation of provision

The bill denies the earned income credit to taxpayers who claim deductions under section 913, as well as to those who claim the benefits of sections 911 or 931.

Effective date

The amendment made by this provision applies to taxable years beginning after December 31, 1977.

b. Treatment of earned income credit as earned income under AFDC and SSI (secs. 101(a)(2) (A) and (B) of the bill and secs. 402 and 1612 of the Social Security Act)

Present law

Under present law, the earned income credit is not taken into account as income for purposes of determining eligibility for, or the amount of, benefits or assistance under any Federal program or State or local program that is financed in whole, or in part, with Federal funds.

Reasons for change

The Revenue Act of 1978 repealed the provisions of present law requiring that the earned income credit be disregarded for purposes of

Federal or Federally-aided assistance programs, effective in 1980. However, conforming changes were not made to the Social Security Act.

Explanation of provision

The bill amends the Social Security Act to provide that the earned income credit would be treated as earned income for purposes of the aid to families with dependent children (AFDC) and supplemental security income (SSI) programs. This treatment applies both to any advance payments made by an employer and to any refund of Federal taxes made by reason of the earned income credit (because the actual credit for a year is larger than the total amount of advance payments for that year). If advance payments of the earned income credit exceed the actual credit, so that the individual must return the difference, some reconciling increase in AFDC or SSI benefits would be made by the welfare agency. This increase could be computed, for example, by reducing by this difference the amount of earned income that is taken into account for purposes of these programs in the month the difference is returned.

Effective date

The amendments made by these provisions apply to payments for months beginning after December 31, 1979.

c. Correction of effective date for advance payment of earned income credit (sec. 101(a)(2)(C) of the bill and sec. 105(g)(2) of the Act)

Present law

The Revenue Act of 1978 contained a new provision allowing employees to elect to have advance payments of the earned income credit added to their paychecks each pay period. In order to give employers time to implement procedures necessary to accommodate for the advance payment of the earned income credit to their employees, the Congress intended this provision to be effective with respect to wages paid after June 30, 1979.

Reasons for change

Due to a typographical error, the Act referred to wages paid after June 30, 1978.

Explanation of provision

The bill corrects a typographical error in the Act to provide that the provision is effective with respect to wages paid after June 30, 1979.

The committee has become aware that some employers may not be able, by July 1, 1979, to provide advance payments to eligible employees, despite good faith efforts to comply with the requirements of this provision. These employers may require additional time to make necessary adjustments in their payroll systems. Thus, the committee expects that, until December 31, 1979, the Internal Revenue Service will liberally exercise its present authority to waive any penalties which might otherwise apply to employers who do not make advance payments but who have made good faith efforts to comply with these provisions. During this time, it is the committee's intention to examine the operation of this provision to evaluate problems that might

Calendar No. 534

96TH CONGRESS
1st Session

SENATE

REPORT
No. 96-498

TECHNICAL CORRECTIONS ACT OF 1979

REPORT

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ON

H.R. 2797

DECEMBER 13 (legislative day, NOVEMBER 29), 1979.—Ordered to be printed

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WASHINGTON : 1979

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Calendar No. 534

96TH CONGRESS, 1st Session | SENATE | REPORT No. 96-498

TECHNICAL CORRECTIONS ACT OF 1979

DECEMBER 13 (legislative day, NOVEMBER 29), 1979.—Ordered to be printed

Mr. LONG, from the Committee on Finance, submitted the following

REPORT

[To accompany H.R. 2797]

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The amendments are shown in the reported bill, with the matter proposed to be striken shown in linetype and the matter proposed to be inserted shown in italic type.

I. SUMMARY

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2. Technical Amendments Relating to Individual Income Tax Reductions and Extensions

a. Eligibility for earned income credit for persons claiming section 913 deductions (sec. 101(a)(1) of the bill and sec. 43(c)(1) of the Code)

Present law

Under present law, the earned income credit is not available to taxpayers who are entitled to exclude amounts from income under section 911 (relating to income earned by certain employees in camps) or section 931 (relating to income from sources within the possessions of the United States) for the taxable year. This provision affects only those taxpayers who lived abroad during part of the year since the earned income credit generally is not available to those taxpayers whose principal place of abode for the taxable year is outside the United States.

Reasons for change

The Foreign Earned Income Act of 1978 established a new set of deductions under section 913 of the Code which generally are available to those taxpayers who formerly were entitled to the section 911 exclusion. The committee believes that the credit should continue to be unavailable to the same type of taxpayers who formerly were denied the credit because they qualified for the section 911 exclusion.

Explanation of provision

The bill denies the earned income credit to taxpayers who claim deductions under section 913, as well as to those who claim the benefits of sections 911 or 931.

Effective date

The amendment made by this provision applies to taxable years beginning after December 31, 1977.

b. Treatment of earned income credit as earned income under AFDC and SSI (secs. 101(a)(2) (A) and (B) of the bill and secs. 402 and 1612 of the Social Security Act)

Present law

Under present law, the earned income credit is not taken into account as income for purposes of determining eligibility for, or the amount of, benefits or assistance under any Federal program or State or local program that is financed in whole, or in part, with Federal funds.

Reasons for change

The Revenue Act of 1978 repealed the provisions of present law requiring that the earned income credit be disregarded for purposes of Federal or Federally-aided assistance programs, effective in 1980.

However, conforming changes were not made to the Social Security Act.

Explanation of provision

The bill amends the Social Security Act to provide that the earned income credit would be treated as earned income for purposes of the aid to families with dependent children (AFDC) and supplemental security income (SSI) programs. This treatment applies both to any advance payments made by an employer and to any refund of Federal taxes made by reason of the earned income credit (because the actual credit for a year is larger than the total amount of advance payments for that year). Language is added to the bill as passed by the House of Representatives to make clear that, if advance payments of the earned income credit exceed the actual credit, so that the individual must return the difference, an appropriate reconciling increase in AFDC or SSI benefits would be made by the welfare agency. This increase could be computed, for example, by reducing by this difference the amount of earned income that is taken into account for purposes of these programs in the month the difference is returned; the increase would be equal to the amount of benefits lost in the previous year because of the excess advance payments.

Effective date

The amendments made by these provisions apply to payments for months beginning after December 31, 1979.

c. Correction of effective date for advance payment of earned income credit (sec. 101(a)(2)(C) of the bill and sec. 105(g)(2) of the Act)

Present law

The Revenue Act of 1978 contained a new provision allowing employees to elect to have advance payments of the earned income credit added to their paychecks each pay period. In order to give employers time to implement procedures necessary to accommodate for the advance payment of the earned income credit to their employees, the Congress intended this provision to be effective with respect to wages paid after June 30, 1979.

Reasons for change

Dut to a typographical error, the Act referred to wages paid after June 30, 1978.

Explanation of provision

The bill corrects a typographical error in the Act to provide that the provision is effective with respect to wages paid after June 30, 1979.

The committee believes that the Secretary should interpret the statute in a manner that will address the problems which occur in giving advance payments to agricultural workers in the field. Specifically, the committee believes that employers should not be required to make advance payments to these workers when they are paid on a daily basis because of the administrative difficulties employers would encounter in trying to maintain a list of all workers who had filed advanced payment certificates and, in having each day, every crew leader compare the name of every worker being paid to the names on

Finder's Aid

P.L. 96-223 (94 Stat. 229) Approved April 2, 1980
Crude Oil Windfall Profit Tax Act of 1980
Title III - Home Energy Assistance Act of 1980

Subject	P.L. Section	94 Stat.	H.Rep. 96-304	S.Rep. 96-394	H.C.Rep. 96-817	S.Rep. 96-378
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BEST DOCUMENT AVAILABLE

Public Law 96-223
96th Congress

An Act

To impose a windfall profit tax on domestic crude oil, and for other purposes.

Apr. 2, 1980
[H.R. 3919]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Crude Oil Windfall Profit Tax Act of 1980.

SECTION 1. SHORT TITLE; AMENDMENT OF 1954 CODE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Crude Oil Windfall Profit Tax Act of 1980". 26 USC 1 note.

(b) AMENDMENT OF 1954 CODE.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1954. 26 USC 1 *et seq.*

(c) TABLE OF CONTENTS.—

Sec. 1. Short title; amendment of 1954 Code; table of contents.

TITLE I—WINDFALL PROFIT TAX ON DOMESTIC CRUDE OIL

Sec. 101. Windfall profit tax.
Sec. 102. Allocation of net revenues from windfall profit tax to certain uses.
Sec. 103. Study of effects of decontrol of oil prices and of windfall profit tax.

TITLE II—ENERGY CONSERVATION AND PRODUCTION INCENTIVES

PART I—RESIDENTIAL ENERGY CREDIT

Sec. 201. General provisions relating to credit.
Sec. 202. Renewable energy source expenditures.
Sec. 203. Provisions to prevent double benefits.

PART II—BUSINESS ENERGY INVESTMENT CREDITS

Sec. 221. Changes in amount and period of application of energy percentage.
Sec. 222. Changes in energy property item descriptions.
Sec. 223. Other changes with respect to the investment credit for investment in energy property.

PART III—PRODUCTION OF FUEL FROM NONCONVENTIONAL SOURCES; ALCOHOL FUELS

Sec. 231. Production tax credit.
Sec. 232. Alcohol fuels.

PART IV—ENERGY-RELATED USES OF TAX EXEMPT BONDS

Sec. 241. Solid waste disposal facilities.
Sec. 242. Qualified hydroelectric generating facilities.
Sec. 243. Renewable energy property.
Sec. 244. Certain obligations must be in registered form and not guaranteed or subsidized under an energy program.

PART V—TERTIARY INJECTANTS

Sec. 251. Tertiary injectants.

TITLE III –LOW-INCOME ENERGY ASSISTANCE

Sec. 301. Short title.
Sec. 302. Statement of findings and purpose.
Sec. 303. Definitions.
Sec. 304. Home energy grants authorized.
Sec. 305. Eligible households.
Sec. 306. Allotments.
Sec. 307. Uses of home energy grants.
Sec. 308. State plans.
Sec. 309. Uniform data collection.
Sec. 310. Payments.
Sec. 311. Withholding.
Sec. 312. Criminal penalties.
Sec. 313. Administration.

TITLE IV –MISCELLANEOUS PROVISIONS

Sec. 401. Repeal of carryover basis.
Sec. 402. Disapproval of Presidential actions adjusting oil imports.
Sec. 403. Qualified liquidations of LIFO inventories.
Sec. 404. Exemption of certain interest income from tax.

TITLE I—WINDFALL PROFIT TAX ON DOMESTIC CRUDE OIL

SEC. 101. WINDFALL PROFIT TAX.

(a) IN GENERAL.—

(1) AMENDMENT OF SUBTITLE D.—Subtitle D (relating to miscellaneous excise taxes) is amended by adding at the end thereof the following new chapter:

"CHAPTER 45—WINDFALL PROFIT TAX ON DOMESTIC CRUDE OIL

"SUBCHAPTER A. Imposition and amount of tax.
"SUBCHAPTER B. Categories of oil.
"SUBCHAPTER C. Miscellaneous provisions.

"Subchapter A—Imposition and Amount of Tax

"Sec. 4986. Imposition of tax.
"Sec. 4987. Amount of tax.
"Sec. 4988. Windfall profit; removal price.
"Sec. 4989. Adjusted base price.
"Sec. 4990. Phaseout of tax.

26 USC 4986. **"SEC. 4986. IMPOSITION OF TAX.**

"(a) IMPOSITION OF TAX.—An excise tax is hereby imposed on the windfall profit from taxable crude oil removed from the premises during each taxable period.

"(b) TAX PAID BY PRODUCER.—The tax imposed by this section shall be paid by the producer of the crude oil.

26 USC 4987. **"SEC. 4987. AMOUNT OF TAX.**

"(a) IN GENERAL.—The amount of tax imposed by section 4986 with respect to any barrel of taxable crude oil shall be the applicable percentage of the windfall profit on such barrel.

"(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a)—

"(1) GENERAL RULE FOR TIERS 1 AND 2.—The applicable percentage for tier 1 oil and tier 2 oil which is not independent producer oil is—

"Tier 1	70
"Tier 2	60

"(2) INDEPENDENT PRODUCER OIL.—The applicable percentage for independent producer oil which is tier 1 oil or tier 2 oil is—

"Tier 1	50
"Tier 2	30

"(3) TIER 3 OIL.—The applicable percentage for tier 3 oil is 30 percent.

"(c) FRACTIONAL PART OF BARREL.—In the case of a fraction of a barrel, the tax imposed by section 4986 shall be the same fraction of the amount of such tax imposed on the whole barrel.

"SEC. 4988. WINDFALL PROFIT; REMOVAL PRICE. 26 USC 4988.

"(a) GENERAL RULE.—For purposes of this chapter, the term 'windfall profit' means the excess of the removal price of the barrel of crude oil over the sum of—

"(1) the adjusted base price of such barrel, and

"(2) the amount of the severance tax adjustment with respect to such barrel provided by section 4996(c).

"(b) NET INCOME LIMITATION ON WINDFALL PROFIT.—

"(1) IN GENERAL.—The windfall profit on any barrel of crude oil shall not exceed 90 percent of the net income attributable to such barrel.

"(2) DETERMINATION OF NET INCOME.—For purposes of paragraph (1), the net income attributable to a barrel shall be determined by dividing—

"(A) the taxable income from the property for the taxable year attributable to taxable crude oil, by

"(B) the number of barrels of taxable crude oil from such property taken into account for such taxable year.

"(3) TAXABLE INCOME FROM THE PROPERTY.—For purposes of paragraph (2)—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, the taxable income from the property shall be determined under section 613(a). 26 USC 613.

"(B) CERTAIN DEDUCTIONS NOT ALLOWED.—No deduction shall be allowed for—

"(i) depletion,

"(ii) the tax imposed by section 4986,

"(iii) section 263(c) costs, or 26 USC 263.

"(iv) qualified tertiary injectant expenses to which an election under subparagraph (E) applies.

"(C) TAXABLE INCOME REDUCED BY COST DEPLETION.—Taxable income shall be reduced by the cost depletion which would have been allowable for the taxable year with respect to the property if—

"(i) all—

"(I) section 263(c) costs, and

"(II) qualified tertiary injectant expenses to which an election under subparagraph (E) applies,

incurred by the taxpayer had been capitalized and taken into account in computing cost depletion, and

"(ii) cost depletion had been used by the taxpayer with respect to such property for all taxable periods.

"(D) SECTION 263(c) COSTS.—For purposes of this paragraph, the term 'section 263(c) costs' means intangible drilling and development costs incurred by the taxpayer which (by reason of an election under section 263(c)) may be

SEC. 102. ALLOCATION OF NET REVENUES FROM WINDFALL PROFIT TAX TO CERTAIN USES. 31 USC 555.

(a) SEPARATE ACCOUNT IN TREASURY ESTABLISHED.—The net revenues from the windfall profit tax for each fiscal year beginning after September 30, 1980, and before October 1, 1990, are hereby allocated for accounting purposes to a separate account in the Treasury to be known as the Windfall Profit Tax Account (hereinafter in this section referred to as the "Account"). Establishment.

(b) SPECIFIED USES FOR AMOUNTS IN THE ACCOUNT.—

(1) BASIC NET REVENUES.—In the case of the amount of basic net revenues allocated to the Account for any fiscal year, there shall be a further allocation to subaccounts for the following uses:

Use for	Percent
Income tax reductions	60
Low-income assistance	25
Energy and transportation programs	15

(2) ADDITIONAL NET REVENUES.—In the case of the amount of additional net revenues allocated to the Account for any fiscal year, there shall be a further allocation to subaccounts for the following uses:

Use for	Percent
Income tax reductions	66⅔
Low-income assistance	33⅓

(3) SPECIAL RULE FOR LOW-INCOME ASSISTANCE FOR 1982 AND SUBSEQUENT YEARS.—In the case of any amount allocated under paragraph (1) to the subaccount for low-income assistance for the fiscal year beginning October 1, 1981, or any subsequent fiscal year—

(A) 50 percent shall be allocated to a program to assist AFDC and SSI recipients under the Social Security Act, and 42 USC 1305.

(B) 50 percent shall be allocated to a program of emergency energy assistance.

(c) NET REVENUES DEFINED.—For purposes of this section—

(1) IN GENERAL.—The term "net revenues of the windfall profit tax" means, for any fiscal year, the amount which the Secretary estimates to be the excess of—

(A) the gross revenues from the tax imposed by section 4986 for the fiscal year, over *Ante*, p. 230.

(B) the sum of—

(i) the refunds of and other adjustments to such tax for such fiscal year, plus

(ii) the decrease in the income taxes imposed by chapter 1 resulting from the tax imposed by section 4986. 26 USC 1 *et seq.*

For purposes of subparagraph (A), there shall not be taken into account any revenue attributable to an economic interest in crude oil held by the United States.

(2) BASIC NET REVENUES.—The term "basic net revenues" means the estimated net revenues which would result for any period under the assumptions for such period which were made in enacting the Crude Oil Windfall Profit Tax Act of 1980.

(3) ADDITIONAL NET REVENUES.—The term "additional net revenues" means for any period the net revenues in excess of the basic net revenues for such period.

(d) PRESIDENT TO PROPOSE ALLOCATION OF NET REVENUES.—

Home Energy Assistance Act of 1980

TITLE III—LOW-INCOME ENERGY ASSISTANCE

SHORT TITLE

42 USC 8601 note

SEC. 301. This title may be cited as the "Home Energy Assistance Act of 1980".

STATEMENT OF FINDINGS AND PURPOSE

42 USC 8601

SEC. 302. (a) The Congress finds that—

(1) recent dramatic increases in the cost of primary energy sources have caused corresponding sharp increases in the cost of home energy;

(2) reliable data projections show that the cost of home energy will continue to climb at excessive rates;

(3) the cost of essential home energy imposes a disproportionately larger burden on fixed-income, lower income, and lower middle income households and the rising cost of such energy is beyond the control of such households;

(4) fixed-income, lower-income, and lower-middle-income households should be protected from disproportionately adverse effects on their incomes resulting from national energy policy;

(5) adequate home heating is a necessary aspect of shelter and the lack of home heating poses a threat to life, health, or safety;

(6) adequate home cooling is necessary for certain individuals to avoid a threat to life, health, or safety;

(7) low-income households often lack access to energy supplies because of the structure of home energy distribution systems and prevailing credit practices; and

(8) assistance to households in meeting the burden of rising energy costs is insufficient from existing State and Federal sources.

Grants

(b) It is the purpose of this title to make grants to States to provide assistance to eligible households to offset the rising costs of home energy that are excessive in relation to household income.

DEFINITIONS

42 USC 8602

SEC. 303. As used in this title—

(1) "household" means any individual or group of individuals who are living together as one economic unit for whom residential energy is customarily purchased in common or who make undesignated payments for energy in the form of rent;

(2) "home energy" means a source of heating or cooling in residential dwellings;

(3) "lower living standard income level" means the income level (adjusted for regional, metropolitan, and nonmetropolitan differences and family size) determined annually by the Secretary of Labor based upon the most recent "lower living standard family budget" issued by the Secretary of Labor;

(4) "Secretary" means the Secretary of Health, Education, and Welfare; and

(5) "State" means each of the several States and the District of Columbia.

HOME ENERGY GRANTS AUTHORIZED

SEC. 304. (a) The Secretary is authorized to make grants, in accordance with the provisions of this title, to States on behalf of eligible households to assist such households to meet the rising costs of home energy. 42 USC 8603.

(b) There are authorized to be appropriated $3,000,000,000 for the fiscal year 1981 to carry out the provisions of this title.

(c) For the purpose of affording adequate notice of assistance available under this title, appropriations under this title are authorized to be included in an appropriation Act for the fiscal year preceding the fiscal year for which they are available for obligation. Funds appropriated under subsection (b) of this section shall remain available until expended.

ELIGIBLE HOUSEHOLDS

SEC. 305. (a) Eligible household means any household which the State determines is— 42 USC 8604.

(1) a household in which one or more individuals are eligible for (A) aid to families with dependent children under the State's plan approved under part A of title IV of the Social Security Act (other than such aid in the form of foster care in accordance with section 408 of such Act), (B) supplemental security income payments under title XVI of the Social Security Act, (C) food stamps under the Food Stamp Act of 1977, or (D) payments under section 415, 521, 541, or 542 of title 38, United States Code (relating to certain veterans' benefits); and 42 USC 601. 42 USC 408. 42 USC 1381. 7 USC 2011 note.

(2) any other household with an income equal to or less than the lower living standard income level as determined pursuant to subsection (c) of this section.

(b) Notwithstanding clause (1) of subsection (a), a household which is eligible for supplemental security income payments under title XVI of the Social Security Act, but not eligible under subsection (a)(1)(A), (C), or (D) of this section, shall not be considered eligible for home energy assistance under this title if the eligibility of a household is dependent upon—

(1) an individual whose annual supplemental security income benefit rate is reduced pursuant to section 1611(e)(1) of the Social Security Act by reason of being in an institution receiving payments (under title XIX of that Act) with respect to that individual, 42 USC 1382. 42 USC 1396.

(2) an individual to whom the reduction specified in section 1612(a)(2)(A)(i) of that Act applies, or 42 USC 1382a.

(3) a child described in section 1614(f)(2) of that Act (who is living together with a parent or the spouse of a parent). 42 USC 1382c.

(c) In verifying income eligibility for the purpose of clause (2) of subsection (a), the State shall apply procedures and policies consistent with procedures and policies used by the State agency administering programs under part A of title IV of the Social Security Act. 42 USC 601.

ALLOTMENTS

SEC. 306. (a)(1) From 95 per centum of the sums appropriated pursuant to section 304(b) for the fiscal year 1981, the Secretary shall allot to each State an amount which bears the same ratio to one-half of such 95 per centum as the aggregate residential energy expenditure in such State bears to the aggregate residential energy expenditure for all States. 42 USC 8605.

based on need and ability to expend the funds consistent with the provisions of this title and taking into account the proportion of the original allotments made available to such States under subsection (a) for such year, but with such proportionate amount for any of such other States being reduced to the extent it exceeds the sum which the Secretary estimates such State needs and will be able to use for such period for carrying out such portion of its State application approved under this title, and the total reduction shall be similarly reallotted among the States whose proportionate amounts are not so reduced. In carrying out the requirements of this subsection the Secretary shall take into account the climatic conditions and such other relevant factors as may be necessary to assure that no State loses funds necessary to carry out the purposes of this title. Any amount reallotted to a State under this subsection during a year shall be deemed part of its allotment under subsection (a) for such year.

Reallocations, advance notice and comment period.

(d)(1) Any allocations to a State may be reallocated only if the Secretary has provided thirty days advance notice to the chief executive and to the general public. During such period comments may be submitted to the Secretary.

Publication in Federal Register.

(2) After considering any comments submitted during such period, the Secretary shall notify the chief executive of any decision to reallocate funds, and shall publish such decision in the Federal Register.

(e) The aggregate residential energy expenditure for each State and for all States shall be determined by the Secretary after consulting with the Secretary of Energy.

(f) The allotments made under this section shall be made on the basis of the latest reliable data available to the Secretary.

Indian tribe members, benefits provision.

(g)(1) In any State in which the Secretary determines (after having taken into account the amount of funds available to the State) that the members of an Indian tribe are not receiving benefits under this title that are equivalent to benefits provided to other households in the State, and if the Secretary further determines that the members of such tribe would be better served by means of grants made directly to provide such benefits, the Secretary shall reserve from sums that would otherwise be allotted to such State not less than 100 per centum of an amount which bears the same ratio to the State's allotment for the fiscal year involved as the population of all eligible Indians for whom a determination under this paragraph has been made bears to the population of all eligible households in such State.

(2) The sums reserved by the Secretary on the basis of a determination under this subsection shall be granted to the tribal organization serving the individuals for whom such a determination has been made, or where there is no tribal organization, to such other entity as the Secretary determines has the capacity to provide assistance pursuant to this title.

Eligibility, submittal of plan.

(3) In order for a tribal organization or other entity to be eligible for an award for a fiscal year under this subsection, it shall submit to the Secretary a plan for such fiscal year which meets such criteria as the Secretary may prescribe by regulation.

USES OF HOME ENERGY GRANTS

42 USC 8606.

SEC. 307. Grants for fiscal year 1981 under this title may be used for home energy assistance in accordance with plans approved under section 308.

STATE PLANS

42 USC 8607

SEC. 308. (a) Each State desiring to receive a home energy grant under this title shall submit a State plan to the Secretary, at such time, in such manner, and containing or accompanied by such information as the Secretary deems necessary.

Requirements

(b) Each such State plan shall—

(1) be submitted in accordance with the procedures, timetables, and standards established by the Secretary pursuant to subsection (d)(4) of this section;

(2) designate an agency of the State to be determined by the chief executive to administer the program authorized by this title and describe local administrative arrangements;

Assistance payments

(3) provide for a State program for furnishing home energy assistance to eligible households through payments made in accordance with the provisions of the plan, to—

(A)(i) home energy suppliers,

(ii) eligible households whenever the chief executive determines such payments to be feasible, or when the eligible household is making undesignated payments for rising energy costs in the form of rent increases, or

(iii) any combination of home energy supplier and eligible household whenever the chief executive determines such payments to be feasible, and

(B) building operators, in housing projects established under sections 221(d)(3) and 236 of the National Housing Act of 1968, section 202 of the Housing Act of 1959, section 515 of the Housing Act of 1949, low rent housing established by the United States Housing Act of 1937, and section 8 of the Housing Act of 1974, and State and local government-operated projects in an aggregate monthly amount computed on the basis of the number of eligible tenants making undesignated energy payments in the form of rent times of quotient of the exact costs of residential fuel costs paid as an undesignated part of rent divided by the number of tenants, the amount of such monthly quotient not to exceed a ceiling amount per eligible tenant as determined under regulations by the Secretary annually to be comparable to the amount established for other eligible households, if such operators give assurances to the State that tenants eligible for assistance under this title are not discriminated against with respect to rent;

12 USC 1701q
42 USC 1485
42 USC 1437 note

(4) describe with particularity the procedures by which eligible households in the State are identified and certified as participants;

(5) describe energy usage and the average cost of home energy in the State identified by the type of fuel and by region of the State;

(6) describe the amount of assistance to be provided to or on behalf of participating households assuring (A) that priority is given to households with lowest incomes and to eligible households having at least one elderly or handicapped individual, and (B) that the highest level of assistance is provided to households with lowest incomes and the highest energy costs in relation to income, taking into account—

(i) the average home energy expenditure,

(ii) the proportional burden of energy costs in relation to ranges of income,

(iii) the variation in degree days in regions of the State in any State where appropriate, and

(iv) any other relevant consideration selected by the chief executive including provisions for payment levels for households making undesignated payments in the form of rent;

(7) provide, in accordance with clause (3)(A), for agreements with home energy suppliers under which— Home energy suppliers, agreements.

(A) the State will pay on a timely basis by way of regular installments, as reimbursements or a line of credit, to the supplier designated by each participating household the amount of assistance determined in accordance with clause (6) and shall notify each participating household of the amount of assistance paid on its behalf;

(B) the home energy supplier will charge the household specified in subclause (A), in the normal billing process, the difference between the actual cost of the home energy and the amount of the payment made by the State under this title;

(C) the home energy supplier will provide assurances that the home energy supplier will not discriminate against any eligible household in regard to terms and conditions of sale, credit, delivery and price; and

(D) subject to such subsection (f) of this section the home energy supplier will provide assurances that any agreement entered into with a home energy supplier under this clause will contain provisions to assure that no household receiving assistance under this title will have home energy terminated unless—

(i) the household has failed to pay the amount charged to such household in accordance with subclause (B) for at least two months,

(ii) the household receives a written termination notice not less than thirty days prior to the termination, and

(iii) the household is afforded, in a timely fashion before termination, an opportunity for a hearing by an agency designated by the State;

unless the supplier is located in a State in which the termination policy contains provisions for a longer grace period, or notification period, than that described in this clause;

(8) provide for the direct payment to households to which subclauses (A)(ii) and (iii) of clause (3) applies; Direct payments.

(9) provide for public participation in the development of the plan; Public participation.

(10) provide assurances that the State will treat owners and renters equitably under the program assisted under this title; Owners and renters, equal treatment.

(11) provide that—

(A) the State may use for planning and administering the plan an amount of the funds received by such State under this title not to exceed 5 per centum of the cost of carrying out the plan except that—

(i) upon proof of unusual circumstances and upon application to the Secretary, the State may use an additional amount for planning and administering the plan not to exceed 2½ per centum of the cost of carrying out the plan, and

(ii) in no case may the Federal share of the cost of planning and administering the plan exceed 50 per centum of such cost, and

(B) the State will pay from non-Federal sources the remaining costs of planning and administering the plan and will not use Federal funds for such remaining costs;

(12) describe the administrative procedures to be used in carrying out the plan;

Opportunity for hearing

(13) provide an opportunity for a fair hearing before the State agency designated under clause (2) to any individual whose claim for assistance under the plan is denied or is not acted upon with reasonable promptness;

Weather-related and supply shortage emergencies

(14) provide that, of the funds the State receives for each fiscal year, the State may reserve 3 per centum of the funds to be available for weather related and supply shortage emergencies, and if the State reserves such funds, the plan shall identify—

(A) the procedures for planning for such emergencies,

(B) the administrative procedures designating the emergency and implementing an emergency plan,

(C) the procedures for determining the assistance to be provided in such emergencies, and

(D) the procedures for the use of the funds under this clause for the purposes of this title in the event that there are no emergencies;

(15) provide assurance that there will be, to the maximum extent possible, referral of individuals to, and coordination with, existing Federal, State, and local weatherization and energy conservation efforts;

Outreach activities

(16) provide for outreach activities designed to assure that all eligible households, particularly households with elderly or handicapped individuals, households with individuals who are unable to leave their residences, households with migrants, households with individuals with limited English proficiency, households with working poor individuals, households with children, and households in remote areas, are aware of the assistance available under this title by using community action agencies, area agencies on aging, State and local welfare agencies, volunteer programs carried out under the Domestic Volunteer Service Act of 1973, and other appropriate agencies and organizations within the State including home energy suppliers together with provisions for the reimbursement of such agencies, from administrative funds, for outreach and certification activities;

42 USC 4951 note.

(17) establish procedures for monitoring the assistance provided under the plan including monitoring and auditing any agreements entered into under clause (7) of this subsection and describe the documentation to be required of energy suppliers concerning energy supplied to eligible households;

(18) provide assurances that the State will not reduce regular benefit levels, from the levels of such benefits as of February 26, 1980, in existing federally assisted cash assistance programs, except that in a State which increases such programs solely for the purpose of energy assistance, such increase shall not be considered a part of the regular program for the purposes of this paragraph;

Fiscal control and fund accounting

(19) provide that fiscal control and fund accounting procedures will be established as may be necessary to assure the proper dispersal of and accounting for Federal funds paid to the State under this title;

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(20) provide that reports will be furnished in such form and contain such information as the Secretary may reasonably require, particularly for the carrying out of provisions of section 309; and Reports.

(21) provide assurances in the case described in section 305(a)(2) that the State will not establish any standards of eligibility under this title based on an assets test which counts cars, household and personal belongings, or primary residences and in the case of a household which the State determines to be eligible under section 305(a)(1), no such test will be established under this title.

(c) The State is authorized to make grants to eligible households to meet the rising costs of cooling whenever the household establishes that such cooling is the result of medical need pursuant to standards established by the Secretary. Grants.

(d)(1) The Secretary shall approve any State plan, or modification thereof, that meets the requirements of subsections (b) and (c) and shall not finally disapprove, in whole or in part, any plan, or any notification thereof, for assistance under this title without first affording the State reasonable notice and opportunity for a hearing within the State. Whenever the Secretary disapproves a plan the Secretary shall, on a timely basis, assist the State to overcome the deficiencies in the plan. Plan approval and disapproval.

(2) Where the Secretary determines that a waiver is likely to assist in promoting the objectives of this title, the Secretary may waive compliance with any of the requirements of subsection (b) to the extent and for the period the Secretary finds necessary to enable any such State to carry out the program assisted under this title. Waiver.

(3) The Secretary shall carry out the functions of the Secretary under this section promptly.

(4) The Secretary, as soon as possible after the date of enactment of this title, shall establish criteria and standards for the State plan requirements under subsections (b) and (c) of this section, together with timetables for carrying out the plan.

(e) Any State which makes advances available for activities relating to the development of a State plan and for other activities under this title in substantial compliance with an approved State plan may be reimbursed for such advances from the allocation made to that State under section 306(a) when funds are appropriated to carry out the provisions of this title.

(f) A State agency may exempt small home energy suppliers from the requirements of subsection (b)(7)(D), of this section if the State agency determines that compliance with such subsection, will seriously jeopardize the ability of the small home energy supplier to conduct such business. Exemption.

(g) A State may use funds available under this title for the purpose of providing credits against State tax to energy suppliers who supply such energy at reduced rates to lower income households, but such credit may not exceed the amount of the loss of revenue to such supplier on account of such reduced rate. Any certifications for such tax credits shall be made by the State, but such State may utilize Federal data available to such State with respect to recipients of supplemental security income benefits if timely delivery of benefits to eligible households and suppliers will not be impeded by the implementation of such plan. Credits against State tax.

(h) At the option of the State, any portion of such State's allotment may be reserved by the Secretary for the purpose of making direct payments to eligible households (except for individuals described in Direct payments.

42 USC 1381 section 305(b) (1), (2), and (3)) containing a recipient of supplemental security income benefits under title XVI of the Social Security Act for home energy assistance in accordance with guidelines issued by the Secretary.

Form of payment (i) At the option of the State, payments described in subsection (b) of this section may be made, without limitation, in the form of a duly issued coupon, stamp, or certificate.

UNIFORM DATA COLLECTION

42 USC 8608 SEC. 309. (a) The Secretary, after consultation with the Secretary of Energy, shall establish uniform standards for data collection which shall be used by States in all reports required under this title.

(b)(1) The standards established by the Secretary under this section shall apply to (A) information concerning home energy consumption, (B) the cost and type of fuels used, (C) the type of fuel used by various income groups, (D) the number and income levels of households assisted by this title, and (E) any other information which the Secretary determines to be reasonably necessary to carry out the provisions of this title.

(2) In carrying out this section, the Secretary shall analyze information supplied by the Secretary of Energy on the price structure of various types of fuel, particularly the increases in such price structure as it relates to the financial assistance provided under this title.

Report to Congress. (c) The Secretary shall report annually to Congress concerning data collected under subsection (b).

PAYMENTS

42 USC 8609 SEC. 310. (a) From the amount allotted to each State pursuant to section 306, the Secretary shall pay to the State which has an application approved under section 308 an amount equal to the amount needed for the purposes set forth in the State plan.

(b) Payments under this title may be made in installments in advance or by way of reimbursement, with necessary adjustments on account of overpayments and underpayments.

WITHHOLDING

42 USC 8610 SEC. 311. Whenever the Secretary, after reasonable notice and opportunity for hearing within the State to any State, finds that there has been a substantial failure to comply with any provision set forth in the State plan of that State approved under section 308, the Secretary shall notify the State that further payments will not be made under this title until the Secretary is satisfied that there is no longer any such failure to comply. Until the Secretary is so satisfied, no further payments shall be made under this title.

CRIMINAL PENALTIES

42 USC 8611 SEC. 312. Whoever violates provisions of this title or who knowingly provides false information in any report required under this title shall be fined not more than $10,000 or imprisoned not more than five years or both.

ADMINISTRATION

42 USC 8612. Delegation of authority SEC. 313. (a)(1) The Secretary may delegate any functions under this title, except the making of regulations, to any officer or employee of the Department of Health, Education, and Welfare.

"(A) the real estate investment trust meets the requirements of this part for the taxable year during which it paid the dividend, and

"(B) the aggregate interest received by the real estate investment trust for the taxable year is less than 75 percent of its gross income,

Ante, p. 305.

then, in computing the exclusion under section 116, there shall be taken into account only that portion of the dividend which bears the same ratio to the amount of such dividend as aggregate interest received bears to gross income.

"(3) ADJUSTMENTS TO GROSS INCOME AND AGGREGATE INTEREST RECEIVED.—For purposes of paragraph (2)—

"(A) gross income does not include the net capital gain,

"(B) gross income and aggregate interest received shall each be reduced by so much of the deduction allowable by section 163 for the taxable year (other than for interest on mortgages on real property owned by the real estate investment trust) as does not exceed aggregate interest received for the taxable year, and

26 USC 163

"(C) gross income shall be reduced by the sum of the taxes imposed by paragraphs (4), (5), and (6) of section 857(b).

26 USC 857

"(4) AGGREGATE INTEREST RECEIVED.—For purposes of this subsection, the term 'aggregate interest received' means only interest described in section 116(c)(1).

"(5) NOTICE TO SHAREHOLDERS.—The amount of any distribution by a real estate investment trust which may be taken into account as a dividend for purposes of the exclusion under section 116 shall not exceed the amount so designated by the trust in a written notice to its shareholders mailed not later than 45 days after the close of its taxable year.

"(6) CROSS REFERENCE.—

"For restriction on dividends received by a corporation, see section 243(c)(2)."

26 USC 116 note

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to taxable years beginning after December 31, 1980, and before January 1, 1983.

Approved April 2, 1980.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 96-304 (Comm. on Ways and Means) and No. 96-817 (Comm. of Conference).
SENATE REPORT No. 96-394 (Comm. on Finance).
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WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS:
Vol. 16, No. 14 (1980): Apr. 2, Presidential statement.

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96TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
No. 96-304

CRUDE OIL WINDFALL PROFIT TAX ACT OF 1979

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ON

H.R. 3919

together with

ADDITIONAL, DISSENTING, AND MINORITY VIEWS

[Including cost estimate of the Congressional Budget Office]

JUNE 22, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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No material re social security in this report.

Calendar No. 421

96TH CONGRESS
1st Session

SENATE

REPORT
No. 96-394

CRUDE OIL WINDFALL PROFIT TAX ACT OF 1979

REPORT

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

together with

ADDITIONAL AND SUPPLEMENTAL VIEWS

ON

H.R. 3919

NOVEMBER 1 (legislative day, OCTOBER 15), 1979
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Calendar No. 421

96TH CONGRESS
1st Session

SENATE

REPORT
No. 96-394

CRUDE OIL WINDFALL PROFIT TAX ACT OF 1979

NOVEMBER 1 (legislative day, OCTOBER 15), 1979.—Ordered to be printed

Mr. LONG, from the Committee on Finance, submitted the following

REPORT

[To accompony H.R. 3919]

The Committee on Finance, to which was referred the bill (H.R. 3919) to impose a windfall profit tax on domestic crude oil, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill as amended do pass.

I. SUMMARY

The Finance Committee substitute for H.R. 3919, the "Crude Oil Windfall Profit Tax Act of 1979," imposes a windfall profit tax on domestic oil producers and royalty owners to supplement the decontrol of oil prices announced by the Administration. It also provides for the use of the revenue from the tax to encourage energy conservation, to promote production from alternate energy sources and to ease the burden of higher energy prices on lower-income households.

Over the period 1979–1990, the windfall profit tax will raise $138.2 billion. The various tax cuts provided in the bill will reduce revenues by $32.4 billion. $64.3 billion is set aside in a trust fund to finance aid to lower-income households. An additional $15 billion is set aside in a trust fund to encourage energy efficient transportation. This will leave a surplus of $26.6 billion, which will be available for tax reductions, additional spending or reduction of the national debt.

In fiscal year 1980, the committee substitute will raise $0.9 billion in revenue and involve outlays of $1.2 billion. The revenue gain is expected to be $2.1 billion in calendar year 1980, $9.0 billion in 1981, and $14.1 billion in 1982.

There are six principal parts of the committee substitute:

(1) A windfall profit tax on domestic oil producers and royalty owners.

(2) Tax incentives to encourage energy conservation in homes.

(3) Tax incentives to encourage energy conservation by businesses and production of alternative energy sources.

(4) Programs to assist lower-income households to deal with higher energy prices.

(5) Establishment of a Transportation Trust Fund, a Low-Income Energy Assistance Trust Fund, and a Taxpayer Trust Fund.

(6) Repeal of carryover basis.

Windfall profit tax

The windfall profit tax is an excise, or severance, tax on domestic oil producers and royalty owners. On each barrel of taxable crude oil, the tax equals the tax rate multiplied by the "windfall profit." The windfall profit equals the selling price of the oil minus the sum of a base price, which will vary depending on the tax tier into which the oil falls, and an adjustment for severance taxes on the windfall profit. The committee believes that this tax will reduce profits of oil producers and royalty owners, rather than be passed on to consumers as higher prices.

In designing the tax, the committee attempted to reduce or eliminate the tax burden on those types of oil the production of which is likely to be relatively sensitive to changes in tax rates or prices. It tried to maintain a higher tax burden on types of oil whose production is likely to be less sensitive to price changes. This greater concern for production incentives is a significant difference between the committee substitute and the House bill.

To encourage greater oil production, the committee decided to exempt from the tax newly discovered oil, incremental production resulting from use of tertiary recovery techniques, heavy (low-gravity) oil, and the first 1,000 barrels per day of stripper oil produced by independent producers. Also, the committee substitute reduces the harsh treatment of Alaskan oil under the House bill by providing it with the same base price received by other upper tier oil. The substitute reduces the tax burden on high water-cut oil. The committee substitute, however, increases the tax rate on old oil (tier one) to 75 percent because the production of this oil is less sensitive to price and because it receives the greatest benefit from decontrol.

Other exemptions from the tax in the committee substitute are designed to avoid imposing a tax burden on income devoted to public purposes. For this reason, oil production owned by State or local governments, Indian tribes or nonprofit educational or medical institutions specifically is exempted from the tax.

Finally, the committee substitute phases out the windfall profit tax after the cumulative net revenue raised by it exceeds $127.1 billion, 90 percent of the estimated revenue which would otherwise be raised by the tax through 1990.

The windfall profit tax in the committee substitute will raise $4.6 billion in calendar year 1980, $11.8 billion in 1981, $15.2 billion in 1982 and $138.2 billion in the 11-year period 1980 to 1990. In fiscal year 1980 it is expected to raise $2.3 billion.

Residential energy conservation

The committee substitute uses part of the revenue provided by the windfall profit tax to finance tax incentives to encourage energy conservation in residences.

The present 15-percent home insulation credit, which was enacted in 1978, is extended to heat pumps, airtight wood stoves, efficient replacement oil or gas furnaces, and (at a 25-percent rate) replacement coal furnaces or boilers. The solar energy credit is increased to 50 percent of the first $10,000 of expenditures and extended to the year 2000. Also, changes are made to the structure of these credits, including making them available to landlords.

The committee substitute also includes a tax credit for utilities which participate in programs to finance investments in residential energy conservation.

The residential energy tax incentives are expected to reduce revenues by $0.4 billion in calendar year 1980, $0.5 billion in 1981, $0.6 billion in 1982 and $8.3 billion between 1980 and 1990. In fiscal year 1980, the revenue loss is expected to be $131 million.

Business energy incentives

The committee substitute provides significant tax incentives to encourage businesses to conserve energy and produce alternative sources of energy.

Solar and wind energy.—The present refundable 10-percent energy investment credit, which is available in addition to the regular investment credit, is increased to 20 percent, extended through 1990 and expanded to include equipment to provide process heat.

Geothermal energy.—The present 10-percent energy investment credit is increased to 20 percent and extended through 1990.

Ocean thermal energy.—The substitute adds a 20-percent energy investment credit for equipment to use ocean thermal energy.

Hydroelectric power.—The substitute provides a 10-percent energy investment credit and more rapid depreciation for property to generate electricity from small scale hydroelectric plants at existing dams and new sites where no dam is involved. Tax exemption is provided for industrial development bonds used to finance dams and hydroelectric equipment.

Conservation.—The present 10-percent energy investment credit is extended to nonoil cogeneration equipment, industrial heat pumps, equipment used to burn petroleum coke and pitch, and modifications to alumina electrolytic cells. Also, a liberal transition rule is provided for energy credits which would otherwise expire after 1982. Many of the new and existing energy credits are extended to public utilities. The Treasury's regulatory authority to add new items to the business energy conservation credit is repealed.

Biomass.—The energy credit is increased to 20 percent for equipment and other property used to burn biomass (other than wood) or to process it into a solid fuel. Also, tax exemption is provided for industrial development bonds used to finance facilities to use solid waste as fuel.

Alternative fuel production credit.—A nonrefundable tax credit is provided for production of certain alternative energy sources. Eligible

fuels include oil shale; tar sands; liquid, gaseous, or synthetic solid fuel produced from coal liquefaction or gasification facilities; unconventional natural gas; gas produced from biomass; steam produced from solid agricultural products; and processed wood. The credit will be $3.00 per barrel of oil-equivalent (based on the energy content of the fuel relative to a barrel of crude oil) and will phase out as imported oil prices rise from $23.50 to $29.50. The credit would be indexed fully for inflation occurring after 1979.

Gasohol.—To encourage production of gasohol, the committee substitute replaces the present gasoline excise tax exemption for gasohol with a 40-cent refundable tax credit for domestic alcohol fuel made from substances other than oil, gas or coal and a 10-cent credit for alcohol fuel made from coal.

The business energy tax incentives will reduce revenue by $0.2 billion in calendar year 1980, $0.3 billion in 1981, $0.4 billion in 1982 and $15.0 billion in the 11-year period 1980–1990. The revenue loss is $78 million in fiscal year 1980.

Lower-income energy assistance

Direct cash payments will be made by the Social Security Administration to SSI recipients and by State welfare agencies to AFDC recipients and to food stamp households which do not receive AFDC or SSI benefits. The funds available ($1.2 billion in fiscal year 1980 and $3 billion in fiscal years 1981 and 1982) will be allocated among the States under a formula which reflects household energy expenditures, heating degree days, and number of low-income persons. Benefit amounts will be determined on a uniform basis within each State, taking into account the amount of the State's allocation and the number of recipent households. Benefit amounts for multiperson households will be 150 percent of the amounts for single individuals, with a $10 monthly minimum in either case. States will be permitted the option of receiving the funds as a block grant and utilizing them to provide energy-related assistance according to a State-devised plan.

Taxpayers will be allowed a nonrefundable tax credit equal to a percentage of the amount spent for heating their homes. The percentage will be different for each heating source and will be based on the extent to which the increase in the cost of these fuels has exceeded increases in the cost of living. The credit will be subject to a minimum of $30 per household ($20 in 1979) and a maximum of $200 per household, and it will phase out between incomes of $20,000 and $22,000 ($18,000 and $20,000 in 1979).

Trust funds

The committee substitute establishes three trust funds. An amount equal to one-half of the net receipts from the windfall profit tax will be placed in a Low-Income Energy Assistance Trust Fund. One-fourth of the net receipts, up to $15 billion, will go into a Transportation Trust Fund. An amount of general revenues resulting from the decontrol of oil prices is to be set aside in a Taxpayer Trust Fund to assure that adequate resources are available to the Congress for action it may wish to take next year to provide relief to taxpayers who face the combined impact of higher prices as a result of oil decontrol and a

D. Lower-Income Energy Assistance

1. Low-Income Energy Assistance: Direct Payments or Block Grants Program (sec. 321 of the bill and new sections 412, 1619, and 1132 of the Social Security Act)

Present Law

There are a number of governmental programs designed to provide assistance to low-income families and individuals. Some of these programs are designed to meet specific needs. This is the case, for example, with the medicaid program, which provides assistance to the poor in obtaining health care, and the food stamp program, which is directed at meeting nutritional needs of low-income households. Other programs are designed to provide general income aid to assist low-income persons in meeting their overall living costs. The major federally assisted program of general income support for families is aid to families with dependent children. This program provides income assistance to needy families in which the children have been deprived of support because at least one parent is deceased, disabled, absent from the home, or (at State option) unemployed. For low-income families with children which are primarily dependent upon earnings, general income aid is provided by the earned income tax credit—a refundable credit equal to 10 percent of earnings up to $5,000 (a maximum annual credit of $500) and phased out over an income range of $6,000 to $10,000. For individuals who are needy because of age, blindness, or disability, general income support is provided through the program of supplemental security income (SSI). This program provides a basic monthly Federal payment (reduced to take into account other income available to the individual) which (at State option) may be supplemented by an additional State-funded payment.

As a rule, the programs designed to provide general income assistance establish uniform payment amounts among individuals or families of similar category, composition, and income with the recipients being responsible to determine how that assistance will be used for the various budget items such as food, clothing, fuel, shelter, and so forth. In some instances, States vary AFDC payments according to differences in shelter costs or, less often, according to other specific budgetary needs of individual families. Similarly, individual differences in budgetary needs are sometimes reflected in the determination of State payments made in supplementation of SSI benefits. In general, however, the trend in recent years has been away from the use of individual budget items in favor of greater use of the flat grant approach.

Reasons for Change

Energy costs have risen substantially over the past few years and particularly so in the past year. Gasoline prices have now risen by over 30 percent, while residential energy prices climbed more than 17 percent above last year's levels. Among residential energy sources, fuel oil prices have increased most dramatically, by over 30 percent through May and over 40 percent through July. However, other residential energy prices have also moved upward substantially—exceeding 20 percent for gas and 5 percent for electricity.

Increases have also taken place to some extent in benefits under programs for low-income families. The Revenue Act of 1978 modified the earned income tax credit, and the increased entitlement will largely be received by eligible families in early 1980. The supplemental security income program for the aged, blind, and disabled is indexed to cost of living changes, and benefit levels under that program accordingly increased by 9.9 percent in July of this year, with a further increase of the same approximate magnitude expected next July. The food stamp program is similarly indexed to account for rising food prices. Increased benefit levels under the AFDC program depend upon State action, but the open-ended matching nature of that program assures that Federal funding will be available to pay for approximately 50 to 83 percent of any increases provided by the States under that program.

The committee is concerned that the ordinary mechanisms for adjusting income assistance programs to rising costs of living may be inadequate to meet the extraordinary increases which have taken place in energy costs, particularly because energy costs for many low-income households may represent a large and vitally important element of their budgets. For this reason, the committee believes it is essential, in addition to the tax credit (described below) for increased residential heating costs of low-income taxpayers, to provide a special adjustment to the existing programs of supplemental security income and aid to families with dependent children which can provide energy related income assistance to recipients of those programs as well as to other low-income people who do not directly benefit from those programs but are recipients of food stamps. The committee recognizes that the particular hardships worked by increased energy costs do not fall evenly on all low-income households and that many States have developed (or have the capacity to develop) programs of assistance which may be better able to target the available funds to the most severely affected cases. For this reason, the committee proposal includes an option for States to utilize the available funds to operate a block-grant program of their own devising as an alternative to the more general approach otherwise applicable under the committee provision.

Explanation of the Provision

General

As described in part F of this report, the committee substitute establishes a Low-Income Energy Assistance Trust Fund which would receive one-half of the net receipts of the windfall profit tax

established by the bill. The amounts in this trust fund would be available to meet the revenue costs of the residential heating energy tax credit and the costs of the program of cash assistance for low-income households. Through fiscal year 1982, the amount of funding for the cash payments program would be approximately $3 billion per year ($1.2 billion for fiscal 1980 when the program would be in effect with respect to only a portion of the full year). Before the end of fiscal 1982, the committee intends to review the program and the manner in which it operates and to propose further legislation concerning the form this type of assistance should take in subsequent years.

Allocation of funds

The purpose of the cash payments program is to help low-income households cope with the extraordinary increases which have been occurring in the cost of energy. It is the objective of the committee substitute to provide assistance in as equitable a manner as possible. The committee recognizes that accomplishing that objective will make it necessary to take into account a variety of factors and that there is not now available all of the data that might be desirable for that end. However, the committee believes that it has developed an allocation formula which reasonably accounts for the elements which ought to be considered.

It is clear that all low-income households have suffered from the impact of rising energy costs. For this reason, the committee substitute provides that one-half of the available funding for the cash payments program is to be allocated among the States in proportion to the total costs of energy usage of low-income households (including residential and nonresidential usage) in each State compared with the total of such costs for low-income households nationally. Because data for computing this factor are not now available, the committee substitute provides, for the fiscal 1980 allocation, a substitute factor of total residential energy expenditures as estimated for 1979. Starting with fiscal 1981, the factor of total low-income household energy costs will be available on the basis of a study to be conducted by the Department of Health, Education, and Welfare, and that factor will be used for 1981 and 1982. The allocations would be adjusted as necessary to assure a $10 monthly minimum payment for all recipient households.

Although all low-income households have suffered from increased energy costs, a particular hardship has fallen on those households in the very coldest parts of the country who must pay for heavy fuel usage during a substantial part of the year. To recognize this particular need, the committee bill provides that the other half of the funds for the cash payments program will be allocated among the States on the basis of the average annual number of heating degree days for each State multiplied by the number of households in the States with incomes below 125 percent of the official poverty line. (Currently, 125 percent of the poverty line is about $7,300 for a four-person family. The number of heating degree days is the total of the number of degrees below 65° Farenheit on all the days on which the average temperature in the State was below that temperature. For example, if the average temperatures for a three day period are 60°, 68°, and 64°, there would be 5 heating degree days for the first day,

none for the second, and one for the third or a total of 6 for the period. The degree day factor in the bill is based on the average annual total for each State measured since July 1931 when statistics first began to be compiled.)

Direct payments program

Prior to the beginning of each fiscal year (or in the case of fiscal 1980, as soon as possible after enactment), the Secretary of Health, Education, and Welfare would determine the allocation described above and, from it, would establish benefit amounts for each State on the basis of the funding allocated for each State divided by his best estimate of the number of recipient households in the State (after setting aside 10 percent of the total for administrative costs). Recipient households would consist of households in which an individual receives SSI, AFDC, or food stamps. In making this determination, the Secretary would do so on the basis of a payment amount for multi-person households which would be 150 percent of the payment amount for households consisting of one individual with a $10 minimum monthly amount.

The benefit amounts determined under the above procedure for SSI and AFDC households would be paid to those households by the Social Security Administration (in the case of SSI recipients) and by the State or local welfare agency (in the case of AFDC recipients). Payments would not vary in different areas of a State and would be made monthly throughout the year in the form of an additional amount included in the regular monthly benefit checks. The income levels for establishing eligibility under these programs would not be affected in any way by these additional payments.

The benefit payments to food stamp recipients would be made by the State or local welfare agency at least twice each year and would not vary across different areas of a State. Prior to disbursing funds to the States for making payments to food stamp recipients, the Secretary of Health, Education, and Welfare would re-estimate on the basis of the best data then available the expected costs of the payments to AFDC and SSI recipients. If it then appeared that total amount of expected payments would exceed the overall allocation for the year, the Secretary would proportionately reduce the amount available for payments to food stamp recipients (and the resultant benefit amounts) so as to avoid exceeding the year's total allocation insofar as possible.

The committee recognizes that establishing a program of this nature represents a significant administrative undertaking both for the Social Security Administration and for the State and local welfare agencies who will be involved. The committee substitute therefore provides for setting aside 10 percent of the available funding to cover State and Federal administrative costs. In addition, to ease the initial administrative difficulties, the bill would permit payments to be made to recipients on the basis of the information on file at the time as to such factors as State of residence without a requirement for retroactive adjustments if this information proved to be incorrect. The committee expects, however, that the agencies involved will as quickly as feasible to develop the capability for more sophisticated administration of the

program. A particular problem is the lack of information concerning which food stamp households also contain SSI and AFDC recipients. States would be expected, insofar as practicable, to avoid making duplicate payments to food stamp households which are also receiving payments on the basis of AFDC or SSI eligibility, and any such duplicate payments made after October 1, 1980, would be subject to recovery. While States might in many instances be unable to prevent such duplication before that date, they would be encouraged to move as rapidly as possible in that direction by a provision permitting them to retain half of any savings based on preventing duplicative payments prior to October 1, 1980.

The committee substitute also provides that erroneous payments under this program would be specifically excluded from the calculation of overall error rates in the AFDC, SSI and food stamp programs; the Secretary of Health, Education, and Welfare would have the discretion to account for these programs either through the existing program accounting structure or separately as he determines to be the more feasible.

1980 payment

As described above, the committee substitute provides for a monthly payment program for AFDC and SSI recipients. For fiscal year 1980, this program would be effective starting with May 1980 under the ordinary provisions of the bill. However, in order to allow additional time to prepare for the operation of a monthly payments program and to make the funds available as soon as possible for individuals who are severely affected this winter, the bill permits the entire fiscal 1980 allocation amount to be paid in a single payment as soon as possible after enactment. The Administration has advised the committee that such a payment can be made within about 90 days after enactment.

Block grant option

In order to assure that assistance to low-income households can quickly and efficiently be made available, the committee bill establishes the above described modifications to the existing federally operated program of supplemental security income and the existing federally assisted program of aid to families with dependent children. Benefits are also provided for an additional already defined category of recipients—food stamp recipients—with payments to be made through the AFDC agencies. The committee recognizes, however, that at least in the near term this method of distributing funds will frequently not match the particular hardships caused by higher energy costs which may vary widely even within a given State from one recipient to another. The committee is also aware that many States have been developing the capacity to provide energy-related assistance to low-income households on a basis more carefully targeted to individual need than is possible under a general payments program of the type described above.

To allow and encourage those States which have the capacity and willingness to operate separate programs of this type to do so, the committee bill gives States the option of receiving the available funding in the form of a block grant. States could elect to receive the funds

otherwise allocated for their State for any one or more of the three categorical eligibility groups (SSI recipients, AFDC recipients, Food stamp recipients not receiving AFDC or SSI). If a State wishes to exercise this option, only the following requirements would apply: (1) if the State wished to utilize the block grant approach for fiscal 1980, notice would have to be given by the Governor to the Department of Health, Education, and Welfare within 15 days after enactment of the bill; (2) election to begin or cease using the block grant approach for fiscal years after 1980 would have to apply to the full fiscal year and notice of a State's election would have to be given at least 90 days prior to the start of the fiscal year; (3) the State would have to agree that block grant funds would have to be used only to provide assistance to lower-income households (according to a definition to be established by the State) to meet needs related to increased energy costs; (4) assistance would have to be provided on an equitable basis to lower income Indian households within the State; and (5) any unused funds would have to be returned to the Federal Treasury.

States electing to utilize the funds on a block-grant basis would be specifically permitted to use these funds to operate a program under which suppliers of residential heating fuel would receive a State tax credit to offset reductions that they allow in the fuel charges of lower income households. Another specifically permitted option would be a program of vendor payments to suppliers for heating fuel provided to lower income households. Under these options, any certifications of eligibility for such households would have to be administered by appropriate State agencies. (States would have access for this purpose to SSI eligibility information under existing data exchange provisions.)

Treatment of benefits under other programs

The committee substitute provides that any assistance provided under this section to lower-income households would not be counted for purposes of determining eligibility or benefit amount under any Federal or State program which is based on need.

Allocation table

The table below shows the State by State allocation of the $3 billion annual funding amount on the basis of data now available. For fiscal year 1981 the allocation will differ to some degree since the factor of total low-income energy costs will then be available and will be substituted for the factor of total residential energy expenditures. (In the table below, one-half of the allocation is based on the total residential energy expenditures in each State as a percentage of the national total. One-half of the allocation is based on each State's usual annual heating degree days multiplied by its low-income (below 125 percent of poverty) population as a percentage of those two factors for all States.) The allocations in this table are adjusted to reflect the amounts which would be payable under a payments program to AFDC, SSI, and Food Stamp recipients in which multi-person households receive 150 percent of the amount paid to single person households. A monthly $10 minimum for either single or multi-person household is also assumed. The first column does not represent benefit

amounts under the payments program but shows how much each State would receive under this allocation in relation to its total low-income population. Because the low-income population exceeds the number of AFDC, SSI, and food stamp recipients, the amounts in the first column are in some cases lower than the $120 minimum which applies to those categories.

Distribution of $3 Billion in Low-Income Energy Assistance Under Finance Committee Formula

State	Annual amount per low-income household	Distribution of funds	
		Millions of dollars	Percentage
Total	$291	$3,000.00	100.00
Alabama	[1] 110	46.30	1.54
Alaska	465	6.29	.21
Arizona	133	24.39	.81
Arkansas	[1] 117	29.76	.99
California	125	196.96	6.57
Colorado	231	36.89	1.23
Connecticut	364	49.64	1.65
Delaware	240	8.37	.28
District of Columbia	147	10.32	.34
Florida	[1] 83	65.29	2.18
Georgia	[1] 102	55.57	1.85
Hawaii	[1] 113	4.52	.15
Idaho	264	13.61	.45
Illinois	267	186.14	6.20
Indiana	267	81.23	2.71
Iowa	283	43.48	1.45
Kansas	221	28.38	.95
Kentucky	148	53.99	1.80
Louisiana	[1] 89	39.01	1.30
Maine	302	24.82	.83
Maryland	251	50.27	1.68
Massachusetts	319	101.29	3.38
Michigan	269	146.99	4.90
Minnesota	330	74.90	2.50
Mississippi	[1] 92	31.52	1.05
Missouri	188	77.49	2.58
Montana	260	13.72	.46
Nebraska	236	23.68	.79
Nevada	207	8.07	.27
New Hampshire	368	15.84	.53

See footnote at end of table.

Distribution of $3 Billion in Low-Income Energy Assistance Under Finance Committee Formula—Continued

State	Annual amount per low-income household	Distribution of funds	
		Millions of dollars	Percentage
New Jersey	295	108.40	3.61
New Mexico	149	16.81	.56
New York	256	323.90	10.80
North Carolina	138	74.38	2.48
North Dakota	309	11.49	.38
Ohio	255	166.63	5.55
Oklahoma	140	37.16	1.24
Oregon	193	31.51	1.05
Pennsylvania	241	190.75	6.36
Rhode Island	274	17.29	.58
South Carolina	134	33.66	1.12
South Dakota	265	12.06	.40
Tennessee	139	62.01	2.07
Texas	[1] 110	119.28	3.98
Utah	235	15.63	.52
Vermont	277	10.98	.37
Virginia	205	62.35	2.08
Washington	200	44.85	1.49
West Virginia	175	32.18	1.07
Wisconsin	351	74.62	2.49
Wyoming	247	5.38	.18

[1] The amount shown in this column for each State represents the total dollar allocation to the State divided by the total number of low-income households. The number of low-income households exceeds the total number of AFDC, SSI, and food stamp households. If the program of payments to AFDC, SSI, and food stamp households is operated in this State, each such household would receive a minimum annual payment of $120.

2. Tax Credit for Users of Residential Energy (sec. 301 of the bill and new sec. 44F of the Code)

Present Law

There is no tax provision in present law dealing with residential heating costs.

Reasons for Change

The committee believes that a portion of the revenues from the windfall profit tax should be directed to lower income taxpayers to provide relief from the burden of higher residential energy costs. Although the price increases facing users of heating oil have been especially dramatic, all residential energy sources have become more

LOW-INCOME ASSISTANCE

Heating bills of all Americans are soaring, but in considering the uses and distribution of tax revenues, a primary objective of the committee was to assure that those segments of the population most adversely affected by the decision to decontrol oil be assisted in bearing the resultant financial burden. This means principally those low and lower middle income households that heat their homes with oil and other energy sources whose price is directly responsive to oil. Within this group people have difficulty paying the price to heat their homes during the winter.

The committee's income assistance program is to provide aid in the form of a small tax credit for all households with incomes below $20,000, a slightly larger credit for those that heat with oil, propane and imported Canadian natural gas, and cash grants to recipients of AFDC, SSI and food stamps. Flexibility is given to those States which desire to revise the target populations.

We fully recognize that the committee's program is the result of compromises made by all members and is in one sense comprehensive. However, it departs from our original intentions. We did not set out to institute a general tax cut, particularly one which is large in its application but small—some would say nominal—in its effect. Rather, we sought a program of targeted, and substantial assistance to the principal victims of unprecedented price increases that are directly attributed to the soaring price of oil.

The committee's decision was reached in a spirit of comity and in the recognition that other persons also face high energy costs. We may, however, have ended up—with respect to the $20 minimum "general" tax credit—spending a significant amount of money in a way that will provide a tiny amount of assistance to a very large number of people. Included are many whose energy costs, while possibly high, cannot be attributed to the decontrol of domestic petroleum prices—the reason that we have a windfall profits tax at all. The relief offered is token. It helps little, if at all, while using up funds that could be far better employed to aid those with greater and more pressing needs.

SOLAR AND CONSERVATION CREDITS

S. 1760, introduced by Senator Packwood on behalf of himself, each signer of these views, and also Senators Dole, Wallop, and Boren, provided tax incentives for a range of conservation and alternative energy sources, including the purchase by individuals and businesses of conservation property, renewable energy property (solar, wind, geothermal, hydroelectric, biomass and ocean thermal energy conversion), cogeneration property and for the production of alcohol fuels. We are encouraged that the windfall profits bill which was reported by the Committee contains most of these provisions (although modified to provide lower credit percentages and shorter duration in most cases), tax credits for high efficiency wood stoves and residential furnaces as well as important additional production subsidies for oil shale and certain unconventional gases. The windfall profits tax is an excellent source of revenues for financing these credits.

there are no fuel costs involved in generating hydroelectric power. Operating costs for hydroelectric facilities are extremely low, allowing rapid retirement of construction costs and low fees for power thereafter. The United States should move quickly to develop to its fullest extent our capacity for generating hydroelectric power.

The use of tax exempt financing for hydroelectric construction is attacked by the administration on the grounds that expansion of the use of tax exempt financing into this field will increase interest rates, driving out other tax exempt borrowers such as schools and hospitals. The administration position has no basis in fact. Historically, when the investments eligible for tax exempt financing have been expanded, the markets have expanded to absorb the new issues without affecting interest rates. In recent years two major new markets for tax exempt bonds have developed without affecting interest rates. These two major new markets were pollution control facilities and housing mortgage bonds.

The tax exempt bond market has consistently expanded in volume year by year without affecting interest rates on tax exempt bonds. The interest rate on tax exempt bonds is not tied to the volume of bonds issued but to the cost of money generally. The Treasury and the Federal Reserve System do more to affect the interest rate on tax exempts than any conduct in the market. The market for tax exempt bonds is not a closed market with a limited volume all its own, but a market like other markets, which interacts with markets for other financial assets. The Treasury appears to view this market as closed, with a finite possible size in spite of historical evidence to the contrary.

LOW-INCOME ENERGY ASSISTANCE

Low-income people are particularly hard hit by rising energy prices. Although the price of energy generally has tracked with the cost of living, the heating problems of the poor are exacerbated by the sheer size of heating bills. The poor of America felt the harsh rise in the price of home heating oil last year through prices which began the steep upward trend during the winter. This winter promises to be even worse for the poor and any effort we in the Congress can take to alleviate the problem is important.

The low-income energy assistance provisions of the committee substitute are a step in the right direction. The committee substitute will help soften a portion of the higher fuel costs experienced by low-income individuals. The direct benefit payment to individuals and households will be a welcome addition to this winter's budgets. The fuel budget will also benefit from the tax credits which low-income taxpayers will receive. Together these provisions give a wide range of energy assistance and allow the States to administer programs which are already underway or under consideration by the various States. The committee was properly concerned that funds be available for distribution this winter so that America's poor need not suffer through another winter without some help. For that reason it was very encouraging to see the Senate act expeditiously to appropriate funds for this purpose.

category or production. It is all oil which is essential to heat homes and propel the machinery of commerce.

TIER 2

Fortunately, the committee rejected a 75 percent tax rate on the so-called Tier 2 oil. A 75 percent tax rate on Tier 2 oil would have further eroded the market incentives provided by decontrol. Reduced funds available for reinvestment by a higher windfall profits tax on Tier 2 would have diluted incentives to stimulate production from existing reservoirs. One energy company estimated that an increase in the windfall profit tax rate from 60 percent to 75 percent for Tier 1 and 2 would reduce production by 1985 by 200,000 barrels per day and recoverable reserves by 700 million barrels.

The committee adopted a number of changes I suggested which make the bill more palatable. The committee agreed to eliminate cumulative deficiencies for purposes of determining the volume of oil taxable in Tier 1. The committee accepted a clarifying amendment which makes expenditures of tertiary injectants deductible in the year injected. Because of the complexity of the payment of the tax, the committee adopted new rules and specifically provided relief for independent refiners. In addition, the committee agreed to exempt certain charitable organizations from the tax.

ENERGY CREDITS

The committee has also agreed to a host of credits of dubious validity. During the Energy Tax Act of 1977 I opposed most of these same credits. Essentially, most expenditures are made on an economic basis. Fuel switching and conservation will occur when the economics of the situation dictate the most prudent course to take. It does not make any sense to subsidize activities which are already economical. If the government chooses to subsidize certain investments it should choose those which provide the greatest energy saving for the least amount of expenditure.

LOW- AND MIDDLE-INCOME ENERGY ASSISTANCE

Undoubtedly, crude oil decontrol will increase somewhat the energy costs of all Americans, but the burden of higher prices will fall most heavily on lower income individuals. The average energy costs of low income households are now approaching 25-percent of annual income and total energy costs may claim half of a poor person's income. Thus, the provisions in this bill aimed at alleviating the higher energy costs of lower income individuals are absolutely essential. By directly addressing the needs of the poor, we have more flexibility to pursue the necessary programs, such as decontrol, that are aimed at increasing America's total energy supply.

One-half of the net windfall profits tax proceeds will be dedicated to providing energy aid to low and middle income citizens. The bill sets up a program for 1980 through 1982 to provide additional energy assistance payments to participants in the AFDC, SSI and Food Stamp programs. The State by State allocation of money under this program is correctly weighted on the basis of climate and actual average energy

expenditures in the State. While the committee's low income energy assistance program may not be a perfect plan, it will provide a good short range solution while we develop a better one. To a large extent, the committee was thwarted in the development of a better plan by the administrative limitations of the Department of Health, Education, and Welfare and the States.

A vital part of the low income aid plan is the State's option to take any or all of its allocation in the form of block grant. Under this option, the electing States will be free to device its own program to provide energy assistance to the poor. I anticipate a number of States will demonstrate they are far more capable of effectively delivering such assistance than is the Federal Government.

Another key part of the bill is the tax credit for users of residential energy. This credit is not just limited to the poor, but is available to middle income taxpayers up to $18,000 in 1980 and $22,000 thereafter. This tax credit will provide a minimum of $20 to every household ($30 in 1981 and thereafter). Families that heat with fuels that are becoming increasingly more expensive, such as heating oil and propane, may receive more than the minimum tax credit, up to a maximum of $200. This tax credit should provide at least some energy assistance to millions of beleagured taxpayers.

CARRYOVER

Finally, the committee has adopted a significant nonenergy related amendment. The committee decided by an overwhelming vote of 19–0 to recommend the repeal of the onerous and misguided carryover basis rules enacted by the Tax Reform Act of 1976.

The Tax Reform Act of 1976 changed the law with respect to the income tax basis of a decedent's property to provide in general, for a carryover of the decedent's basis with certain adjustments. The change was very controversial and applicable to estates of decedents dying after December 31, 1976. The Revenue Act of 1978 contained an amendment which I sponsored with Senator Byrd of Virginia to delay the effective date of the carryover basis provisions for three years until December 31, 1979.

I believe that carryover basis is a complicated disaster. There is no question that the 1976 law is riddled with complexities that defy even the most sophisticated tax technician. Even if the inordinate complexities can be eliminated, which I doubt, there still remains many difficulties with carryover basis. First of all, it is often difficult to prove basis. The recordkeeping requirements and the question regarding fiduciary responsibility should not be overlooked. Carryover basis also increases the relative tax burden. The impact of carryover basis must be examined from the standpoint of both death taxes and income taxes generated by the sale of assets to pay for estate taxes. The cumulative effect of Federal estate tax, State death taxes, the Federal and State income taxes imposed upon an estate will often consume nearly all of the assets. The harsh tax results that flows from selling assets to raise money to pay death taxes should not be allowed to continue. I am afraid many small businesses and farmers will suffer.

Carryover basis was a mistake. Congress must erase this grievous error.

BOB DOLE.

The cash payments program for low income households is intended to guarantee that every household has sufficient resources to meet its basic needs. Without such a program, the "heat or eat" decision will become a daily part of life for millions of Americans. But identifying which Americans and the extent of the need in individual cases was beyond the competence of the committee because we are not informed as to the energy consumption characteristics of low income households and cannot reach a large portion of the population in need—particularly the elderly—with existing Federal assistance programs. We can correct the information problem with additional study and legislation in the next session. We have provided a state block grant option with broad definitions of eligibility to achieve maximum participation.

To some extent the income assistance portion of this legislation works at cross-purposes with the tax incentives for conservation and fuel conversion. This is particularly true of the credits for low and middle income families designed to offset the high cost of energy. Because these credits are based on volumetric consumption, they provide a subsidy for higher levels of energy use as Senator Danforth has ably and consistently stated. However, without these credits, American families of low and moderate income are left defenseless against an energy inflation that is affecting all fuels and too rapid to allow gradual adjustment. I support the tax credits as a short-term measure to provide equity for those not able to afford rapid adjustment and not eligible for programs of cash assistance.

These views are as much an agenda for additional action as they are a personal explanation and appeal on specific issues. H.R. 3919 deserves the support of every Senator but that support should serve as the foundation and not the capstone of our national energy policy. It is a good start, but nevertheless only a start, on a decade that will fix the pattern of our energy future.

DAVE DURENBERGER.

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96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 96-817

CRUDE OIL WINDFALL PROFIT TAX ACT OF 1980

MARCH 7, 1980.—Ordered to be printed

Mr. ULLMAN, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 3919]

The Committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 3919) to impose a windfall profit tax on domestic crude oil, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. SHORT TITLE; AMENDMENT OF 1954 CODE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Crude Oil Windfall Profit Tax Act of 1980".

(b) AMENDMENT OF 1954 CODE.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1954.

(c) TABLE OF CONTENTS.—

Sec. 1. Short title; amendment of 1954 Code; table of contents.

TITLE I—WINDFALL PROFIT TAX ON DOMESTIC CRUDE OIL

Sec. 101. Windfall profit tax.
Sec. 102. Allocation of net revenues from windfall profit tax to certain uses.
Sec. 103. Study of effects of decontrol of oil prices and of windfall profit tax.

TITLE II—ENERGY CONSERVATION AND PRODUCTION INCENTIVES

PART I—RESIDENTIAL ENERGY CREDIT

Sec. 201. General provisions relating to credit.
Sec. 202. Renewable energy source expenditures.
Sec. 203. Provisions to prevent double benefits.

PART II—BUSINESS ENERGY INVESTMENT CREDITS

Sec. 221. Changes in amount and period of application of energy percentage.
Sec. 222. Changes in energy property item descriptions.
Sec. 223. Other changes with respect to the investment credit for investment in energy property.

PART III—PRODUCTION OF FUEL FROM NONCONVENTIONAL SOURCES; ALCOHOL FUELS

Sec. 231. Production tax credit.
Sec. 232. Alcohol fuels.

PART IV—ENERGY-RELATED USES OF TAX EXEMPT BONDS

Sec. 241. Solid waste disposal facilities.
Sec. 242. Qualified hydroelectric generating facilities.
Sec. 243. Renewable energy property.
Sec. 244. Certain obligations must be in registered form and not guaranteed or subsidized under an energy program.

PART V—TERTIARY INJECTANTS

Sec. 251. Tertiary injectants.

TITLE III—LOW-INCOME ENERGY ASSISTANCE

Sec. 301. Short title.
SEC. 302. Statement of findings and purpose.
Sec. 303. Definitions.
Sec. 304. Home energy grants authorized.
Sec. 305. Eligible households.
Sec. 306. Allotments.
Sec. 307. Uses of home energy grants.
Sec. 308. State plans.
Sec. 309. Uniform data collection.
Sec. 310. Payments.
Sec. 311. Withholding.
Sec. 312. Criminal penalties.
Sec. 313. Administration.

TITLE IV—MISCELLANEOUS PROVISIONS

Sec. 401. Repeal of carryover basis.
Sec. 402. Disapproval of Presidential actions adjusting oil imports.
Sec. 403. Qualified liquidations of LIFO inventories.
Sec. 404. Exemption of certain interest income from tax.

"(c) APPLICATION WITH OTHER DEDUCTIONS.—No deduction shall be allowed under subsection (a) with respect to any expenditure—

"(1) with respect to which the taxpayer has made an election under section 263(c)), or

"(2) with respect to which a deduction is allowed or allowable to the taxpayer under any other provision of this chapter."

(2) TECHNICAL AND CONFORMING AMENDMENTS.—

(A) The table of sections for such part VI is amended by adding at the end thereof the following new item:

"Sec. 193. Tertiary injectants."

(B) Section 263(a)(1) (relating to capital expenditures) is amended—

(i) by striking out "or" at the end of subparagraph (E),

(ii) by striking out the period at the end of subparagraph (F) and inserting in lieu thereof ", or", and

(iii) by adding at the end thereof the following new subparagraph:

"(G) expenditures for tertiary injectants with respect to which a deduction is allowed under section 193."

(C) Section 1245(a) (relating to gain from dispositions of certain depreciable property) is amended—

(i) by striking out "or 190" each place it appears in paragraphs (2)(D) and (3)(D) and inserting in lieu thereof "190, or 193",

(ii) by inserting "193," after "190," each place it appears in paragraph (2), and

(iii) by inserting "or 193" after "190" in the last sentence of paragraph (2).

(D) Section 1250(b)(3) (relating to depreciation adjustments) is amended by striking out "or 190" and inserting in lieu thereof "190, or 193".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1979.

TITLE III—LOW-INCOME ENERGY ASSISTANCE

SHORT TITLE

SEC. 301. This title may be cited as the "Home Energy Assistance Act of 1980".

STATEMENT OF FINDINGS AND PURPOSE

SEC. 302. (a) The Congress finds that—

(1) recent dramatic increases in the cost of primary energy sources have caused corresponding sharp increases in the cost of home energy;

(2) reliable data projections show that the cost of home energy will continue to climb at excessive rates;

(3) the cost of essential home energy imposes a disproportionately larger burden on fixed-income, lower income, and lower

middle income households and the rising cost of such energy is beyond the control of such households;

(4) fixed-income, lower-income, and lower-middle-income households should be protected from disproportionately adverse effects on their incomes resulting from national energy policy;

(5) adequate home heating is a necessary aspect of shelter and the lack of home heating poses a threat to life, health, or safety;

(6) adequate home cooling is necessary for certain individuals to avoid a threat to life, health, or safety;

(7) low-income households often lack access to energy supplies because of the structure of home energy distribution systems and prevailing credit practices; and

(8) assistance to households in meeting the burden of rising energy costs is insufficient from existing State and Federal sources.

(b) It is the purpose of this title to make grants to States to provide assistance to eligible households to offset the rising costs of home energy that are excessive in relation to household income.

DEFINITIONS

SEC. 303. As used in this title—

(1) "household" means any individual or group of individuals who are living together as one economic unit for whom residential energy is customarily purchased in common or who make undesignated payments for energy in the form of rent;

(2) "home energy" means a source of heating or cooling in residential dwellings;

(3) "lower living standard income level" means the income level (adjusted for regional, metropolitan, and nonmetropolitan differences and family size) determined annually by the Secretary of Labor based upon the most recent "lower living standard family budget" issued by the Secretary of Labor;

(4) "Secretary" means the Secretary of Health, Education, and Welfare; and

(5) "State" means each of the several States and the District of Columbia.

HOME ENERGY GRANTS AUTHORIZED

SEC. 304. (a) The Secretary is authorized to make grants, in accordance with the provisions of this title, to States on behalf of eligible households to assist such households to meet the rising costs of home energy.

(b) There are authorized to be appropriated $3,000,000,000 for the fiscal year 1981 to carry out the provisions of this title.

(c) For the purpose of affording adequate notice of assistance available under this title, appropriations under this title are authorized to be included in an appropriation Act for the fiscal year preceding the fiscal year for which they are available for obligation. Funds appropriated under subsection (b) of this section shall remain available until expended.

WITHHOLDING

SEC. 311. Whenever the Secretary, after reasonable notice and opportunity for hearing within the State to any State, finds that there has been a substantial failure to comply with any provision set forth in the State plan of that State approved under section 308, the Secretary shall notify the State that further payments will not be made under this title until the Secretary is satisfied that there is no longer any such failure to comply. Until the Secretary is so satisfied, no further payments shall be made under this title.

CRIMINAL PENALTIES

SEC. 312. Whoever violates provisions of this title or who knowingly provides false information in any report required under this title shall be fined not more than $10,000 or imprisoned not more than five years or both.

ADMINISTRATION

SEC. 313. (a)(1) The Secretary may delegate any functions under this title, except the making of regulations, to any officer or employee of the Department of Health, Education, and Welfare.

(2) The Secretary shall issue regulations under this title, within sixty days after the date of enactment of this title.

(b) In administering the provisions of this title, the Secretary is authorized to utilize the services and facilities of any agency of the Federal Government and of any other public agency or institution, to the extent such services and facilities are otherwise authorized to be made available for such purpose, in accordance with appropriate agreements, and to pay for such services either in advance or by way of reimbursement as may be agreed upon.

(c)(1) Notwithstanding any other provision of law, the amount of any fuel assistance payments or allowances provided to an eligible household under this title shall not be considered income or resources of such household (of any member thereof) for any purpose under any Federal or State law, including any law relating to taxation, public assistance or welfare program.

(2) Section 5(d) of the Food Stamp Act of 1977 is amended by striking out "and (10)" and inserting in lieu thereof the following: "(10) during fiscal year 1981, any income attributable to an increase in State public assistance grants which is intended primarily to meet the increased cost of home energy, and (11)".

(d) The Secretary shall establish procedures for Federal monitoring of State administration of programs assisted under this title.

(e) The Secretary shall coordinate the administration of the program established under this title with appropriate programs authorized by the Economic Opportunity Act of 1964 and any other existing Federal energy programs which provide related assistance programs.

(f) The Secretary, after consultation with the Secretary of the Department of Energy, the Director of the Community Services Administration, the Secretary of Housing and Urban Development and the Secretary of Agriculture, shall establish procedures for referrals for participation in Federal weatherization programs under section 308(b)(15).

IV. LOWER INCOME ENERGY ASSISTANCE

68. Low income energy assistance

House bill.—No provision.

Senate amendment.—The Senate amendment authorizes for fiscal years 1981, 1982 (and 1983, unless rescinded by a vote of either House), a program of block grants to the States to provide assistance to low-income families for heating and cooling costs. The total amount of appropriations authorized is $3.025 billion for fiscal year 1981 and $4.025 billion for fiscal years 1982 and 1983.

Eligibility is limited to households with income less than the Bureau of Labor Statistics lower living standard, and to households who receive food stamps, AFDC, income-tested Veterans' pensions, and with certain exceptions, SSI.

Funds are allotted by formula to the States and territories. The basic formula includes a State's residential energy expenditures and the square of its heating degree days. However, the allotment of any State otherwise entitled to less than $100 million would be increased under an alternative allotment percentage by an amount necessary to provide at least $120 per year to each AFDC, SSI, and food stamp household in the State. Further, no State would receive less than the lower of the amounts it would have received under either of two alternative formulas. Increases in allotments which result from either the minimum or from the alternative formulas would result in pro rata reductions in the allotments of other States, except that up to $25 million is authorized to meet the additional costs resulting from the application of the minimum benefit provision to certain States.

Each State receiving funds is required to submit an energy assistance plan which meets certain conditions and which is subject to approval by the Secretary of Health, Education, and Welfare. Assistance could be given directly to eligible households; to suppliers of energy to these households, in the form of either cash or tax credits; and to operators of subsidized housing projects.

Conference agreement.—The conference agreement generally follows the Senate amendment, with the following modifications:

1. The conference agreement provides an authorization effective only for fiscal year 1981;
2. An additional authorization of $90 million is provided for any States, the allotment of which would otherwise be equal to or greater than $100 million, for increases in such States' allotments through the use of the alternative allotment percentage.
3. If the amount appropriated for fiscal year 1981 is less than the present $3 billion primary authorization and the amounts necessary under the separate $25 million and $90 million authorizations, then each State's allotment shall be determined as if this sum had been appropriated and shall be reduced on a pro rata basis as necessary.

4. Where the Secretary determines that a waiver is likely to assist in promoting the objectives of this program, the Secretary may waive compliance with any of the State plan requirements. The conferees also wish to make clear that a State is not required, under its plan, to provide a benefit to every household defined as an eligible household under this title. The funds authorized in this part may not be used to provide benefits, however, to households not included in this definition.

5. The conferees wish to make clear that the regulations which are required to be issued within sixty days after enactment may be interim regulations.

6. The conference agreement requires that fuel assistance payments or allowances provided under this title will not be considered income or resources of an eligible household for any purpose under a Federal or State law. The conferees wish to emphasize that this provision applies regardless of whether the fuel assistance is paid directly to the household or to the supplier of energy to the household. Thus, under any law, such as the Food Stamp Act of 1977, which provides that benefits may depend on the expenditures of the household for fuel, any portion of these expenditures which may be paid by the fuel assistance program authorized in this conference agreement will not be considered a resource available to this household, even if the payment is made directly to the energy supplier. Thus, under such a law, benefits will be computed as if the total cost of the fuel, including the amount of assistance provided, had been paid by the household.

7. The amendment in the Senate provsion to the Food Stamp Act is effective only for fiscal year 1981.

8. With regard to SSI recipients, the conference agreement provides the States with an option whereby they may have the Secretary retain any portion of their energy allotment for the purpose of making direct Federal payments to SSI recipients. The conferees recognize that time requirements to design and test the computerized programs needed to administer the direct Federal payments will require the Secretary to establish an early date for States to indicate interest in Federal issuance of energy payments to SSI recipients. The conferees are also aware that constraints in computer process capacity will require the Secretary to establish, in cooperation with the States, nationwide criteria and standards to which the States must adhere when submitting specifications for such direct Federal payments.

9. Various technical amendments are made in the Senate amendment to clarify the language.

69. Tax credit for users of residential energy

House bill.—No provision.

Senate amendment.—The Senate amendment provides a nonrefundable tax credit equal to a percentage of the amount spent during the year for heating a principal residence. The percentage is different for each heating source and is determined by the Secretary of the Treasury according to a formula which reflects the extent by which the increase in the price of the heating source since 1978 exceeds the over-

AL ULLMAN,
DAN ROSTENKOWSKI,
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JAMES C. CORMAN,
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WILLIAM R. COTTER,
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RUSSELL B. LONG,
H. E. TALMADGE,
HARRY F. BYRD, JR.,
GAYLORD NELSON,
MIKE GRAVEL,
LLOYD BENTSEN,
DAN MOYNIHAN,
BOB DOLE,
BOB PACKWOOD,
BILL ROTH,
JOHN C. DANFORTH,
Managers on the Part of the Senate.

Calendar No. 396

96TH CONGRESS
1st Session

SENATE

REPORT
No. 96-378

HOME ENERGY ASSISTANCE ACT

OCTOBER 25 (legislative day, OCTOBER 15), 1979.—Ordered to be printed

Mr. WILLIAMS, from the Committee on Labor and Human Resources, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany S. 1724]

The Committee on Labor and Human Resources, to which was referred the bill (S. 1724) to authorize the Secretary of Health, Education and Welfare to make grants to States in order to provide assistance to households which cannot meet the high cost of fuel, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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STATEMENT OF THE PROBLEM

On June 26. 1979. the OPEC members increased the price of oil from $14.54 per barrel to $20.12 per barrel, representing a 38 percent increase. A further increase is very likely to occur in December. These increases coupled with the impact of decontrol will mean a 100 percent increase in heating bills for many Americans this year.

On fuel prices, the American people have suffered a 293 percent increase between 1972 and 1979. The projections of future fuel price increases are cause for alarm. In addition, during this same period, natural gas prices have increased approximately 155 percent with electric rates rising about 91 percent. While the cost of home energy has skyrocketed during these years, the average worker's weekly earnings have only increased by 59 percent.

These unprecedented energy cost increases caused many low-income Americans to pay an average of 25 percent of their incomes on utility costs last year and elderly households to pay approximately 30 percent. Projections for this year show average low-income households paying 50 percent of their income on home energy expenditures alone. Many, particularly those on fixed incomes, will pay considerably more.

Consequently, it is imperative that the Congress take immediate action to provide funds for this year and to enact a longer term program to address the need for assistance caused by these unprecedented increases in energy costs.

SUMMARY

S. 1724 authorizes an energy assistance program for low and lower middle income households for three years, 1980–1982. $1.6 billion is authorized for fiscal year 1980, $3 billion for fiscal year 1981, and $4 billion for fiscal year 1982. The program is a discretionary grant program subject to appropriations. It is not an entitlement and thus is a controllable budget item.

The fiscal year 1980 program is based on existing authority under the Economic Opportunity Act while the program beginning in fiscal year 1981 is a new Act which provides for formula block grant to States. HEW will be the federal administering agency.

Each State will submit a State plan which details the State's administrative arrangements. Assistance will be provided through payments to energy suppliers on behalf of eligible households or as cash assistance directly to the eligible household. Eligible households are those at or below the Bureau of Labor Statistics Lower Living Standard Income Level. As recipients of SSI, AFDC, Food Stamps, and certain needs tested veterans pensions are below the Lower Living Standard Income Level for the most part, those recipients were made categorically eligible in order to ease administrative requirements.

NEED FOR THIS LEGISLATION*

Until the early 1970's, relative energy price stability existed in the United States Historically, Americans have paid little by world standards for their energy and supplies have been inexhaustible. How-

*The information in this report concerning the need for low-income energy assistance is adapted from the Report of the Fuel Oil Marketing Advisory Committee of the U.S. Department of Energy, dated June 1979.

BEST DOCUMENT AVAILABLE

ever, beginning in 1973, changes in international and national economic and governmental policies caused energy prices to increase dramatically, with crude oil prices more than quadrupling between 1973 and 1978.

Energy prices increased at a significantly higher rate than inflation over this period. Inflation from 1972–1978 increased the Consumer Price Index by 60 percent while fuel oil/coal prices increased 152 percent in the same time period.

Low income households have been hit hard by this increase in energy costs—far harder than they would have been had energy cost increases simply matched the rate of inflation. Further, the increase in energy cost has taken, proportionally, a much larger bite out of the low-income family's budget than it has out of the budget of other families. While the average household spent approximately 4.7 percent of its annual income on energy for household purposes in 1978 (fuel and utilities, excluding transportation and gasoline), the average low income household spent over 18.4 percent of its income on household fuel and utilities. It should be stressed that the above data reflects the national average cost. A wide range of cost differences exist as heating requirements, type of fuel utilized, and cost of energy vary from region to region. In New England, for example, 1978 expenditures for energy costs exceed 30 percent of income for low income households.

Data from a Community Services Administration Crises Intervention Program in Milwaukee, Wisconsin show that poverty level clients of this Program were using over ⅕ (20.5 percent) of their income on gas heating bills and oil users were spending 31.8 percent of their income on heating bills during the winter months (October through March). Total fuel and utility bills for gas users represented 25.7 percent of their income; for oil users total fuel and utility bills represented 45.7 precent of monthly income. These low income families spend 81.9 percent of their monthly income on total shelter (heating, utilities and housing) if they used gas and 92.9 percent of monthly income if they used oil.

The increases in energy prices since 1972 have meant that the poor, whose average income has not increased in real terms, have lost ground in real purchasing power. In 1972 low-income persons spent approximately $216, on the average, on home fuels and utilities. If fuel prices had risen with the general rate of inflation, low-income families would have spent approximately $340 on energy costs in 1978. However, estimates indicate that an average low-income family was spending approximately $604 on household energy costs. This increase represents an average loss of purchasing power of $265, due to rising energy costs over and above general inflation.

In the aggregate, this would indicate that the 16.2 million low-income households would have suffered a loss of over $4 billion in purchasing power in 1978—$4 billion of income transferred away from the most economically disadvantaged in our society because of escalating prices.

Energy price increases between 1973 and 1978 have caused a problem of crisis proportion for many low income households. Now on top of this already difficult situation, additional price increases are placing an impossible burden on low income households. Increases in the past

year for residential fuel oil vary between 70 and 90 percent and many estimate that prices will increase by over 100 percent before the end of this winter.

The rhetoric of the terms "food or fuel", "heat or eat" are now becoming a reality. It is incumbent upon the government to provide a program of assistance to ease the hardship caused the poor by high energy prices.

The Federal Government first responded to the problems faced by low-income households due to increasing energy costs in 1973. The Community Services Administration's predecessor agency, the Office of Economic Opportunity (OEO), using previously appropriated funds, initiated a weatherization and energy crisis program for the poor at the time of the 1973 fuel crisis.

The Congress favorably viewed these pioneering efforts of the Community Services Administration to grapple with the energy problems of the poor, and, in the Economic Opportunity Act Amendments of 1974, authored by the Labor and Human Resources Committee, added a new section 222(a)(12) to the act entitled Emergency Energy Conservation Services.

This section, now redesignated Section 222(a)(5), provides the specific authority to the Community Services Administration for the development and implementation of emergency energy assistance programs to assist low income households.

The Community Services Administration's emergency energy assistance program has made significant contributions to the health and safety of many low-income and elderly Americans, and in many cases enabled them to survive in the face of dreadful hardships. However, the program has been fraught with operational difficulties including late appropriations and insufficient funds allowed for administration. Administrative problems have hampered the program, particularly the 1978 program. A report by the General Accounting Office on these administrative difficulties has been helpful to this Committee in its oversight of the existing program, where most of the problems have now been eliminated, and in planning for the longer term program which will be administered by HEW.

HISTORY OF S. 1724

In the 96th Congress, six bills were introduced which provide assistance to low income households to offset the rising costs of energy. These legislative measures included:

S. 1724—The Home Energy Assistance Act introduced by Senator Williams and cosponsored by Senators Kennedy, Javits, Metzenbaum, Durkin, Randolph, Pell, Weicker, Jackson, Melcher, Tsongas, Cohen, Sarbanes, Stafford, and Leahy.

S. 1270—The Basic Fuel Assistance Act introduced by Senator Javits and cosponsored by Senators Jackson, Randolph, Pell, Stafford, Riegle, Tsongas, Moynihan, Ribicoff, and Williams.

S. 1725—The Economic Opportunity Act Amendment of 1979 introduced by Senator Nelson and cosponsored by Senators Kennedy, Riegle, Stafford, Melcher, and Durkin.

S. 771—The Energy Stamp Act of 1979 introduced by Senator Weicker.

S. 1331—The Emergency Fuel Assistance Act of 1979 introduced by Senator Biden.

S. 1603—The Home Heating Stamp Act of 1979 introduced by Senator Mathias and cosponsored by Senator Baker.

These measures were referred to the Senate Committee on Labor and Human Resources where they were held at full Committee in order to expedite action.

In order to more clearly consider the legislation before it, the Committee held twelve hearings. The President's proposal for Fuel Assistance for Low Income was also considered. Three of the hearings were held in Washington, D.C. on September 25, 26, and 27, 1979, and were chaired by the Committee Chairman, Senator Harrison A. Williams, Jr. The Aging Subcommittee, chaired by Senator Thomas F. Eagleton held a Washington, D.C. hearing on June 14, 1979.

Field hearings were held in eight states and were chaired by various members of the Committee. Field hearings were held in: Jersey City, New Jersey, chaired by Senator Harrison A. Williams, Jr.; Providence, Rhode Island, chaired by Senator Claiborne Pell; Madison, Wisconsin, chaired by Senator Gaylord Nelson; Lansing, Michigan, chaired by Senator Donald W. Riegle; Philadelphia, Pennsylvania, chaired by Senator Richard S. Schweicker; Salt Lake City, Utah, chaired by Senator Orin G. Hatch; and Concord, New Hampshire, chaired by Senator Gordon J. Humphrey. Related hearings were held by the Subcommittee on Aging on the impact of rising energy prices on the elderly in Kansas City, Missouri, chaired by Senator Thomas F. Eagleton.

The Committee received testimony from a broad range of witnesses that included the Secretary of the Department of Health, Education, and Welfare, Patricia Roberts Harris, the Assistant Secretary for Policy and Planning of the Department of Energy, William Fisher, numerous representative from State and local government, consumers and industry, organizations representing constituent groups including the elderly, the poor, and suppliers and consumers of energy, and others.

There was general agreement that a greatly expanded home energy assistance program is needed to provide aid to lower and lower middle income households in meeting the dramatically rising cost of home heating. There was also discussion of the need for some level of assistance to be provided to certain eligible households, where excessive heat is a factor in threatening life and health.

There was also general agreement, with few exceptions, that the basic program design of any home energy assistance program should provide for a State grant program with ample discretionary authority to be given to the Governors to decide how best to afford relief to its residents.

September 25, 1979, Washington, D.C.

Witnesses included: Mr. William Fisher, Deputy Assistant Secretary, Policy and Planning, Department of Energy; Mr. Anthony Maggiore, Associate Director, Community Relations and Social Development Commission, Milwaukee, Wisconsin. Representing the Fuel Oil Marketing Advisory Committee; Ms. Ellen Berman, Executive Director, Consumers Energy Council of America; Mr. Stephen Schachman,

Chairman, American Gas Association Task Force on Fuel Subsidies; Mr. Frederich Webber, Executive Vice President, Edison Electric Institute, accompanied by Mr. Merl Hertzog, Vice President, Consumer and Community Services; Mr. John Buckley, Vice President, North East Petroleum, introduced by Mr. Robert Sullivan, Executive Vice President, National Oil Jobbers Council; and Senator Joseph R. Biden, Jr.

September 26, 1979, Washington, D.C.

Witnesses included: Senator Henry Jackson, Senator Charles Mathias, Senator David Durenberger, Senator Lawton Chiles, Senator Pete Domenici, Hon. Patricia Roberts Harris, Secretary of Health, Education, and Welfare.

Hon. Hugh Carey, Governor, State of New York; Hon. Ella Grasso, Governor, State of Connecticut; and Hon. Edward Brooke, Chairperson, National Low-Income Housing Coalition.

September 27, 1979, Washington, D.C.

Witnesses included: Congressman Jonathan Bingham; Congressman Baltasar Corrada; Honorable J. Josephy Garrahy, Governor, State of Rhode Island; Mr. Alan Davis, Managing Attorney, National Consumer Law Center, Inc.; Ms. Ruth Toothaker, Consumer, State of Maine; Mr. William Hutton, Executive Director, National Council of Senior Citizens; Mr. David Wilson, Commissioner, Department of Social Welfare, State of Vermont; Ms. Helen O'Bannon, Secretary, Department of Public Works, State of Pennsylvania; Mr. Timothy Wilson, Director, Maine Division of Community Services, State of Maine; Mr. Phillip H. Gillespie, chairman, Energy Committee, National Community Action Agency Executive Directors Association; and Mr. J. C. Banks, Former Executive Director, West Central Action Program, Glenwood, Wisconsin.

In addition, the following individuals and organizations supplied statements for the records:

Hon. Edward King, Governor, Commonwealth of Massachusetts; Hon. Thomas P. O'Neill, III, Lt. Governor, Commonwealth of Massachusetts, Chairman, Federal Funds Subcommittee Coalition of Northeastern Governors (CONEG); Mr. Joseph Langer, Director of Operations, Metropolitan New York Coordinating Council on Jewish Poverty; National Housing Law Project, Washington, D.C.; Senator Claiborne Pell; United Neighborhood Houses of New York, Inc., New York, New York; Senator Howard M. Metzenbaum; Senator Donald W. Riegle, Jr.; Governor Bill Clinton, State of Arkansas; and New York City, New York, New York.

In addition, the names of individuals and organizations who testified at the Committee field hearings appear in the appendix.

COMMMITTEE VIEWS

The Committee determined that assistance for fiscal year 1980 should be provided under the fastest mechanism available. Authority exists for appropriation under the Economic Opportunity Act administered by the Community Services Administration. Using the existing authority to appropriate funds rather than waiting for enactment of new

authority is critical to implement an expanded program of assistance this winter. The Committee chose, therefore, to develop a longer term program to begin in fiscal year 1981 and to use existing authority for fiscal year 1980.

Home energy assistance program for fiscal year 1980

The Labor and Human Resources Committee has jurisdiction over the Economic Opportunity Act of 1964 which contains a provision (Section 222 (a)(5)) authorizing emergency energy assistance. The program provided under this authorization was funded at at level of $200 million in fiscal year 1979 and $250 million has been appropriated for fiscal year 1980 in the Labor-HEW Appropriations Conference Report.

This year the Community Services Administration which has responsibility for the program, taking its guidance from the Labor and Human Resources Committee and the Labor-HEW Appropriations Subcommittee, has rewritten the regulations for this program to provide a program of block grants to States. The Committee exercised its oversight authority in the development of these regulations and is satisfied that the new regulations are appropriate for administration of an expanded program.

Sufficient authority to appropriate $1.6 billion for fiscal year 1980 exists under Section 222(a)(5) of the Economic Opportunity Act. The Committee would urge the Appropriations Committee to act under that authority to make funds available as soon as possible in order to provide assistance for this winter.

The Committee includes authorizing language for fiscal year 1980 in S. 1724 in order to specify its intent for program administration for fiscal year 1980. Since sufficient authority already exists, the statutory language of this Act can be used as report language by the Appropriations Committee in order to provide specifications for this winter's program, in addition to the existing CSA regulations.

The 1980 program in this Act provides that all funds appropriated shall be allotted to states according to a formula based 50% on aggregate energy expenditure and 50% on heating degree days weighted by eligible population. The eligible population according to the CSA regulations are those at or below 125% of the poverty level. For the purposes of counting eligible households for the formula, the Census Bureau poverty guidelines should be used. For the purpose of establishing eligibility for households within a state, the poverty criteria established by the Office of Management and Budget shall be used.

The 1980 program provides for a State option on program administration. Within 15 days of enactment, the Governor shall notify the Director of CSA whether the State will run the entire program directly under the CSA regulations promulgated October 11, 1979 or will have a dual administration with HEW.

Under the dual administration, CSA would transfer to HEW, from the States' allotment, an amount to be specified by the Governor which shall be a proportional amount between 100% and 125% of the proportion of SSI households in the State to all eligible households in the State. HEW will then serve SSI recipients directly through cash payments. SSI recipents in institutions and children receiving SSI

are excluded from this direct payment for energy assistance. The amount of assistance to be made available by HEW to SSI recipients shall be uniform within a State except that payments to households having only one individual shall be ⅔ of the payment to all other households receiving such payments.

The remainder of the States' allotment for States selecting the dual administration shall be administered by the State according to the CSA regulations of October 11, 1979. The Committee does provide that the ceilings contained in those regulations with respect to maximum payments to energy suppliers on behalf of eligible households and cash payments directly to eligible households shall not be in force for this program of assistance.

While eligibility for fiscal year 1980 in the State block grant program is based on the existing CSA regulations which provide for eligibility based on 125% of poverty, the Commission expects states to use already determined income levels for recipients of AFDC, SSI, and Food Stamps in order to speed the eligibility determination process.

Definitions

The Committee used several specific terms which required definition.

(1) "Households" are defined in the bill as an economic unit for which residential energy is customarily purchased in common, or which pays for its residential energy as part of its rent payment. Households may consist of individuals or groups of individuals living together, whether related or unrelated. The basic criterion defining a household is the manner in which residential energy is purchased; the unit that purchases residential energy, either directly or through its rent, is the household. The Committee intends this household definition to be comparable to the household definition used for the Food Stamp Program, including the exclusion of residents of institutions, except that roomers and boarders would, under this Act, be treated as renters.

(2) "Home energy" is defined as electricity, oil, gas, coal or any other fuel used as a residential energy source, whether used in privately owned dwelling, or in rental accommodations or other dwelling arrangements. Other energy sources such as coal, kerosene and wood should also be included. The definition of home energy does not include services such as water and sewer services.

The Committee also included in this definition that home energy refers to the "primary source of heating or cooling." There are certain clarifications needed of this terminology. The Committee used "primary source" because it intends that this Act offset high heating costs (and cooling where medically necessary) and that assistance not be simply a supplement of all utilities and their use to run appliances etc. However, the data that is available on home energy cannot be disaggregated by purpose. Therefore, the aggregate residential energy expenditure levels include all energy used in residential dwellings regardless of purpose.

The Committee also notes that some homes may use heat from several energy sources and thus not have a single "primary source." Also there are situations where the primary heating source is dependent on electricity to trigger the heater. In such cases, the State should

make whatever arrangements are necessary to serve the eligible household.

(3) "Lower living standard income level" is defined as the annually adjusted income levels for a given locality and household size, as derived by the Secretary of Labor from the Bureau of Labor Statistics' annually adjusted "lower living standard family budget." The "lower living standard family budget" itself is an annual income level for a 4-person family and adjusted annually for inflation and changes in consumption patterns and taxes; it is also adjusted for regional and metropolitan/nonmetropolitan cost-of-living differences. For purposes of eligibilty for certain programs under the Comprehensive Employment and Training Act (CETA), it is also adjusted for household size. It is the Committee's intent that the income levels, as adjusted for CETA program eligibility, be the income levels used for the purposes of eligibility and other determinations under this Act, except that the monthly income equivalent of the lower living standard income level may be used in eligibility determinations.

The Committee believes that the measure used to indicate the number of lower and lower middle income households in a State for purposes of allocation of funds and for purposes of determining eligibility should take into account (1) regional differences in the cost-of-living, (2) the differences in the cost-of-living between metropolitan and non-metropolitan areas, and (3) the increases in expenditures necessitated by larger household size. The Committee feels that the indicator which most accurately reflects these concerns is the lower living income standard. Use of the poverty level was rejected as it does not reflect cost-of-living differences. A table setting out the most current annual lower living standard income levels is contained in the Appendix.

(4) "Secretary" is defined as the Secretary of Health, Education and Welfare. For fiscal years 1981 and 1982, the program established by this Act would be administered through the Department of Health, Education and Welfare, with the exception of energy crisis related activities, which would be administered by the Community Services Administration.

(5) State is defined to include the 50 States and the District of Columbia. The formula allocation of funding under this Act is to the 50 States and the District of Columbia, who must meet various State plan requirements. A separate reserve is set aside for Puerto Rico, Guam, American Samoa, the Virgin Islands, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, and they must submit applications for assistance under this Act that are consistent with the Act's State plan requirements.

Authorization levels and revenue source

The Act is authorized for three years. The Committee determined that a longer authorization period would not be appropriate for a new program as substantial oversight and an opportunity for reauthorization within three years is needed for a program of this magnitude. In addition, the Committee feels that the rapidly changing situation with regard to energy costs and credit policies will require reconsideration of the level of need for this program and the most appropriate manner for providing assistance.

Forward funding is authorized in order to allow time for adequate planning for use of funds under this program. The Committee asks the Budget and Appropriations Committees to give consideration to forward funding for fiscal years 1981 and 1982 at the appropriate time.

For fiscal year 1980, $1.6 billion is authorized, the same amount requested by the President for fuel assistance. The authorization level is increased to $3 billion in 1981 and $4 billion in 1982. While the level of appropriations will not begin to totally offset direct home energy price increases for the eligible population, it will ease the burden on those who are least able to withstand large increases.

The President's proposed program of energy assistance is tied to the proposed energy trust fund to be created from the windfall profits tax. As it is not within the jurisdiction of this Committee to deal with taxation or revenues, S. 1724 does not specify the revenue source for funding the program. Because the assistance provided by this Act is desperately needed, the Committee believes it should be enacted and funded as rapidly as possible regardless of revenue source. It is our intent, however, that this program be funded directly from, or the general revenue fund be reimbursed from, the windfall profits tax if the Congress enacts that legislation in sufficient scope to provide for this program of assistance.

Eligible households

The act provides that households will be eligible for assistance if they are:

(1) eligible for Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI) payments, food stamp assistance, or payments by the Veterans' Administration under certain of its needs-tested programs for veterans and their survivors; or

(2) have an income equal to or less than the Bureau of Labor Statistics lower living standard income level applicable to a household of their size and place of residence.

Eligibility would be determined by the State, through the agency or agencies it designates. The Committee intends that household income be the basic eligibility test for households applying for assistance and that assets and other tests not be used.

The Committee includes categorical eligibility for households eligible for assistance under Supplemental Security Income, Food Stamps, AFDC, or under sections 415, 521, 541, or 542 of title 38, United States Code. These sections of the Veterans' and Survivors' Pension Improvement Act of 1978 include (1) households of needy wartime veterans, (2) survivors of wartime veterans receiving improved pension, and (3) households of parents of veterans whose deaths were service connected and who are receiving Dependency and Indemnity Compensation. These programs are all needs based, and households eligible for these programs are overwhelmingly at or below the Bureau of Labor Statistics lower living standard income. Therefore, establishing a categorically eligible population will not expand the eligible population but will decrease the administrative burden of certifying income and eligibility.

The Committee stresses that specific inclusion of certain veteran pensioners does not in any way diminish the right of other Veterans Administration pensioners who can establish eligibility on the basis of income determination.

The categorical eligibility of SSI recipients is limited by denying it to SSI recipients who are residents of Medicaid institutions, those who are living in the household of another person, receiving substantial support from the household and whose SSI payment is accordingly reduced by one-third, and disabled or blind children whose parents are not eligible for SSI aid. Except for residents of institutions, these persons may, of course, attempt to establish income eligibility.

Approximately 18 million households will be eligible for assistance under the criteria established by the Committee. Thus this legislation addresses the needs of both low and lower middle income households. State tables showing the number of households and income level of households at or below the lower living standard by family size are included in the Appendix.

When determining income eligibility for assistance under this Act, State-designated agencies should use policies and procedures consistent with those used by the State agencies administering the AFDC program. However, it is not expected that the income, assets and other tests used for programs administered by such agencies be applied in the case of households requesting aid under this Act. The Committee intends that only the procedures and policies used to verify income by local welfare agencies be used including the policy of considering current or prospective income and acting on an application within 30 days.

In determining what income should be considered in measuring a household's income eligibility for assistance, the Committee intends that total household cash income from all sources be considered—excluding what the State determines to be reasonable allowances for income over which the household has no control or does not actually receive, such as reimbursement for expenses incurred in connection with employment, medical reimbursements, loans, vendor payments, and income that is excluded for purposes of public assistance or taxation by other laws or that is administratively difficult to compute. In this regard, the Committee expects that the policies used by the State welfare agencies would provide a guide for determinations under this Act. In its state plan each State must describe, with particularity, the procedure that it will use to identify and certify eligible households.

The plan must also set up a hearing process for individuals who believe they are eligible and should receive assistance if such assistance is denied. The Committee does not intend that this procedure be followed as a general procedure for those denied assistance, but provides it as a due process protection for individuals who believe they have been unfairly denied assistance.

Allotments

The bill allots 95 percent of the appropriated funds to States using a two part formula. One-half of the 95 percent of the appropriated funds is distributed on the basis of each State's share of aggregate residential energy expenditures in the United States. The other half is distributed on the basis of each State's share of heating degree days

weighted by the State's number of households with incomes equal to or less than the lower living standard. The weighting is done by multiplying each State's number of heating degree days by its number of households with incomes equal to or less than 100 percent of the lower living standard. Each State's share is then determined by dividing this product by the sum of the products for all States.

The formula reflects the Committee's belief that (1) low and low middle income households are in need of energy assistance; (2) the assistance should be designed to offset a portion of the rising costs of home energy, and (3) the problem is most critical in areas with high home heating costs.

Eligible households

In order to determine the number of households with incomes below 100 percent of the lower living standard, a household's total income should be compared to the income standard which reflects that household's size, State, and metropolitan status.

Where CETA regulations concerning the LLS list more than one income level in a State for a given household size and metropolitan status, the Secretary of Health, Education, and Welfare, after consultation with the Secretary of Labor, should determine an average income figure to be used in making allocations to that State. Household income should be determined from the most recent government source which yields reliable State level estimates. The lower living standards should be those promulgated for a comparable year. At the time of this Report, the 1976 Survey of Income and Education was the most recent survey which contained income information and allowed reliable State level estimates.

Tables in the Appendix show the Committee's estimate of households with incomes equal to or less than the lower living standard for each State. Income information was obtained from the Survey of Income and Education and was compared to 100 percent of the lower living standards derived from the 1976 CETA eligibility regulations.

Energy expenditure

Aggregate state residential energy expenditure shall be defined as the Secretary's best estimates, made in consultation with the Secretaries of Energy and Commerce, from studies by the Bureau of the Census, Bureau of Labor Statistics and Energy Information Administration, of total fuel use for home energy purposes for each fuel type in each state, multiplied by the most current available estimates of the cost of said fuels.

It is the intent that such estimates be based as much as possible upon surveys of actual prices. The fuels included in this aggregate shall include fuel oil, kerosene, liquid petroleum gas, natural gas, propane, electricity, and that portion of fuels generally used for commercial purposes which is utilized as home energy including but not limited to residual fuel oil and coal.

If the Secretary determines that the most reliable State level energy data are for a period which is more than one year before the year for which the State allotments are being made, the Secretary shall establish a system for adjusting energy prices for use in the formula to reflect recent changes in energy cost.

land, there is a history of a lack of service provided to eligible Indians from domestic social programs which are administered by State governments. The Committee has included a mechanism whereby Indian tribal organizations whose eligible members are not being served by the State may receive grants made directly to the tribal organization.

When the Secretary determines that eligible Indians are not receiving benefits that are equivalent to non-Indian eligible households, and further determines that the eligible Indian population would be better served directly by the tribal organization, then the Secretary can reserve from the States allotment a per capita share of funds which will then be allocated to the tribal organization. In order to receive funds such organizations must submit a plan for approval by the Secretary.

State plans

Each State which intends to participate in the home energy assistance program must submit a State plan to the Secretary that meets the requirements prescribed by the Secretary with regard to the time and manner of submittal and containing the information required under Section 8 of the Act. The State plan will detail the program to be carried out by the State and after aproval will be the standard by which the state's performance is evaluated. State plans must meet the standards established by the Secretary.

The requirements set forth in this Act are flexible to allow States to develop programs sensitive to the needs in the State.

Administration

The Chief Executive of the State must designate the agency responsible for program administration. While several state agencies may be involved in the program, one agency should be identified as the administering agency in order to assure accountability. The State is free to make whatever local arrangements are most appropriate for program administration.

The State is allowed to use a portion of its grant award for administrative purposes. However, the State must match the administrative funds. Administrative costs from both State and Federal sources shall not exceed 15 percent of the amount of the grant award. The Federal share will be 50 percent of the 15 percent (or 7½ percent of the Federal funds allotted to the state) and the state match of the remaining 50 percent must be provided from non Federal sources.

The State plan should detail the State and local administrative arrangements and procedures and should include descriptions of general administration, outreach activities, determination of eligibility and certification of eligible households and plans for coordination with related agencies and programs. The arrangements for funding local administration, outreach and certification should also be identified.

Type of assistance

Assistance under this Act may be made available either as payments to the energy supplier on behalf of an eligible household or to the eligible household. A State may use a combination of the two types of assistance based on the most feasible approach in a given situation.

Assistance may also be made available to operators of housing projects assisted by Federal, State or local authorities. The Committee wishes to clarify that providing for payments to building operators in

results of this analysis and other data collected in relation to home energy.

In its consideration of measures to aid lower-income households in meeting rising energy costs, the Committee has found that adequate information is not always available or not in a useful form. It is the Committee's intent that the Secretary seek to rectify this scarcity of data on home energy consumption and prices so that improvements can be made in Federal legislation and States can plan more efficient and equitable programs. However, uniform data collection procedures should be phased in so as not to unduly burden States with new data collection requirement.

Payments

Authority is provided to make payments to states in amounts necessary to carry out each state's plan, but not in excess of its allotment. If states cannot utilize their full allotment, the Secretary would provide only a partial payment until the state plan is amended to require additional amounts. For example, if a state could not establish a workable administrative system to use its full allotment, it might have a portion of its allotment deferred until that point in the year in which it begins operating a full-scale program.

Federal payments to the states could be made in installments in advance, or as reimbursements, whichever is more appropriate.

Withholding

The Secretary may withhold payments to states if it is determined that the state is failing to comply with the provisions set forth in its state plan. Withholding would continue until compliance is achieved. In judging whether a state has failed to comply, the Secretary should, of course, take into account unusual circumstances such as unusually severe weather and supply conditions. Withheld funds would not be available for expenditure in a later year.

Criminal Penalities

The Act provides for criminal penalities for violating provisions of the Act on its regulations or for knowingly providing false information in any required report. The penalty would be a fine of not more than $10,000, nor more than 5 years' imprisonment, or both.

States would be responsible for penalties related to violation of their laws or regulations.

Federal administration

The Secretary is authorized to delegate functions under the Act to officers and employees of the Department of Health, Education and Welfare. However, approval of Federal regulations under this Act could not be delegated.

Proposed regulations would be required within 60 days of enactment and the Committee would expect the Secretary to proceed expeditiously with issuance of final regulations.

The Secretary may utilize the services and facilities of other Federal and public agencies, if they are otherwise authorized to be made available, and authorize payments for such services or facilities.

This authority is particularly important in regard to coordination with the Department of Energy and the states in the collection and

analysis of date on home energy consumption. The Committee does not expect the Department of Health, Education and Welfare to assume all responsibility in the area of better energy information. However, the Secretary should monitor and direct collection activities so that any information or analysis will be of use in improving the design of programs under this Act and evaluating the need for assistance.

Benefits granted under this Act will not be considered income or resources under any Federal or State law or program dealing with taxation, public assistance, welfare, or similar needs-tested programs.

The Secretary will establish Federal procedures for monitoring State administration in order to assure efficient operation of the programs established under this Act and allow the Secretary to monitor compliance with State plans.

The Secretary shall coordinate administration of the program under this Act with appropriate Economic Opportunity Act programs and agencies, and any other related Federal energy programs.

The Secertary is required to establish procedures for referral to Fedeal weatherization programs which will be utilized in carrying out the referral responsibilities outlined in State plans. The Committee intends that such procedures will be updated to include any new energy conservation or weatherization programs.

SECTION BY SECTION SUMMARY—HOME ENERGY ASSISTANCE ACT, S. 1724

Section 2—Statement of findings and purpose

The Congress finds that the dramatic increase in fuel prices is placing a financial burden on low, fixed, and lower-middle income households, consequently placing each of these groups in a position of facing economic and health hardships or disasters. The Home Energy Assistance Act was constructed to help alleviate these problems.

Section 3—Definitions

"Eligible households" means any economic unit whose income is equal to or less than the lower living standard issued by the Secretary of Labor. This standard is determined by geographic region and family size. "Secretary" denotes the Secretary of Health, Education, and Welfare who will administer assistance to each State including the District of Columbia.

Section 4—Home energy grants authorized

The Secretary is authorized to make grants available to eligible households within the guidelines of this Act. Authorization for appropriation is $1.6 billion for 1980, $3 billion in fiscal year 1981 and $4 bililon in fiscal year 1982.

Section 5—Eligible households

Establishes eligibility for households with incomes below the BLS lower living standard level and categorical eligibility for those on AFDC, Food Stamps, SSI, and certain income tested veterans pensions.

Finder's Aid

P.L. 96-249 (94 Stat. 357) Approved May 26, 1980
Food Stamp Act Amendments of 1980

Subject	SS Act Section	P.L. Section	94 Stat.	H. Rep. 96-788	H.C. Rep. 96-957	S. Rep. 96-236	S.C. Rep. 96-704
Disclosure Provisions	303	127(b)(1)	366	--	26	--	--
Disclosure Provisions	304	127(b)(2)	367	--	26	--	--
Retrospective Accounting			358-359	78-87	19-20	--	19-20
Periodic Reporting			359-360	87-94	21	--	21
Social Security Office Application			363	133-134	24	--	24

BEST DOCUMENT AVAILABLE

Public Law 96-249
96th Congress

An Act

To amend the Food Stamp Act of 1977 to improve food stamp program fiscal accountability through reductions in inaccurate eligibility and benefit determinations; to improve the system of deductions; to increase the specific dollar limitations on appropriations for the fiscal years 1980 and 1981 food stamp programs; and for other purposes.

May 26, 1980
[S. 1309]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Food Stamp Act Amendments of 1980".

Food Stamp Act Amendments of 1980.
7 USC 2011 note.

TITLE I—REDUCTION IN FOOD STAMP ERROR AND FRAUD AND REVISION OF DEDUCTIONS

MEALS IN SHELTERS FOR BATTERED WOMEN AND CHILDREN

SEC. 101. (a) Section 3 of the Food Stamp Act of 1977 is amended by— 7 USC 2012.

(1) striking out in clause (1) of subsection (g) "and (7)" and inserting in lieu thereof "(7), and (8)"; 93 Stat. 392.

(2) striking out in subsection (g) "and (7)" and inserting in lieu thereof "(7)";

(3) inserting immediately before the period at the end of subsection (g) the following: ", and (8) in the case of women and children temporarily residing in public or private nonprofit shelters for battered women and children, meals prepared and served, by such shelters";

(4) inserting in the last sentence of subsection (i) after "section 1616(e) of the Social Security Act," the following: "temporary residents of public or private nonprofit shelters for battered women and children,"; and 42 USC 1382e.

(5) striking out in clause (2) of subsection (k) "and (7)" and inserting in lieu thereof "(7), and (8)".

(b) Section 10 of the Food Stamp Act of 1977 is amended as follows: 93 Stat. 392. 7 USC 2019.

(1) inserting after "purchased" a comma;

(2) striking out the comma immediately after "residents"; and

(3) inserting after "programs" the following: ", public and private nonprofit shelters that prepare and serve meals for battered women and children".

EXCLUDING ENERGY ASSISTANCE PAYMENTS FROM INCOME

SEC. 102. Section 5(d) of the Food Stamp Act of 1977 is amended by— 7 USC 2014.

(1) striking out "and" before "(10)"; and

(2) inserting before the period at the end thereof the following: ", and (11) any payments or allowances made under any Federal, State, or local laws for the purpose of providing energy assistance".

CONSUMER PRICE INDEX

93 Stat. 390
7 USC 2014
Post, p. 369

SEC. 103. Section 5(e) of the Food Stamp Act of 1977 is amended by inserting "for all urban consumers" after "Consumer Price Index" each time those words appear.

DEPENDENT CARE DEDUCTIONS FOR WORKING ADULTS

SEC. 104. Effective October 1, 1981, section 5(e) of the Food Stamp Act of 1977 is amended by—

(1) in the fourth sentence, amending clause (1) to read as follows: "(1) a dependent care deduction for the actual cost of payments necessary for the care of a dependent regardless of the dependent's age, the maximum allowable level of which shall be $90 per month, per household, when such care enables a household member to accept or continue employment, or training or education that is preparatory for employment, and";

(2) in the fourth sentence, striking out everything after "March 31" down to the period at the end of the sentence; and

(3) in clause (B), striking out "that for the excess shelter expense deduction contained in clause (2) of the preceding sentence" and inserting in lieu thereof the following: "described in clause (1) of the preceding sentence".

EXPANDED MEDICAL DEDUCTIONS FOR THE ELDERLY

SEC. 105. Effective October 1, 1981, section 5(e)(A) of the Food Stamp Act of 1977 is amended by—

(1) inserting "or their spouses" before ", exclusive of special diets,"; and

(2) striking out "$35" and inserting in lieu thereof "$25".

MEDICAL DEDUCTION FOR THE BLIND AND DISABLED IN CERTAIN AREAS

SEC. 106. Effective October 1, 1981, section 5(e) of the Food Stamp Act of 1977 is amended by:

(1) in the fourth and last sentences, inserting "and blindness" after each time "disability" appears; and

(2) in the fourth and last sentences, striking out "title II" each time that it appears and inserting in lieu thereof: "titles I, II, X, XIV, and XVI".

RETROSPECTIVE ACCOUNTING

7 USC 2014.

SEC. 107. Section 5(f) of the Food Stamp Act of 1977 is amended to read as follows:

"(f) Household income for those households that by contract for other than an hourly or piecework basis, or by self-employment, derive their annual income in a period of time shorter than one year, shall be calculated by the State agency for the purpose of determining household eligibility by being averaged over a twelve-month period. For those households that receive nonexcluded income of the type specified in subsection (d)(3) of this section, such income shall be calculated by being averaged over the period for which it is provided. State agencies shall elect and use one of the following two methods in calculating income for all other households:

"(1) taking into account the income reasonably anticipated to be received by the household in the certification period for which

eligibility is being determined and the income that has been received by the household during the thirty days preceding the filing of its application for food stamps so that the State agency may reasonably ascertain the income that is and will be actually available to the household for the certification period; or

"(2) using income received in a previous month as the basis, in accordance with standards prescribed by the Secretary, except for the month of application and subsequent months specified by the Secretary for newly applying households (other than households reapplying within thirty days after the end of a prior certification period). In addition, the Secretary shall make modifications or exceptions to this method of income calculation with respect to households experiencing sudden and significant losses of income (including households experiencing losses of income of $50 per month or more) or the addition of a new member, households in immediate need in accordance with the provisions of section 11(e)(9) of this Act, migrant farmworker households, and other classes of households if the Secretary determines that this method of income calculation would be impracticable to administer or would cause serious hardship for such households. In promulgating regulations governing the method of income calculation described in this subsection, the Secretary shall consult with the Secretary of Health and Human Services so that, wherever feasible, and consistent with the purposes of the applicable Acts, households receiving income under title IV-A of the Social Security Act shall have income calculated on a consolidated and comparable basis.".

7 USC 2020.

Regulations, consultation with Secretary of Health and Human Services.

42 USC 601.

VEHICLE USE BY HANDICAPPED HOUSEHOLD MEMBERS

SEC. 108. The second sentence of section 5(g) of the Food Stamp Act of 1977 is amended by—

7 USC 2014.

(1) inserting after "other than one used to produce earned income" the following: "or that is necessary for transportation of a physically disabled household member"; and

(2) striking out "or to transport disabled household members".

STATE OPTION ON ADMINISTRATIVE FRAUD HEARINGS

SEC. 109. Section 6(b) of the Food Stamp Act of 1977 is amended by inserting after the first sentence thereof a new sentence as follows: "Each State agency shall proceed against such alleged fraudulent activity either by way of administrative fraud hearings in accordance with clause (1) of this subsection or by referring such matters to appropriate legal authorities for civil or criminal action in accordance with clause (2) of this subsection, or both.".

93 Stat. 391.
7 USC 2015.

PERIODIC REPORTING

SEC. 110. Section 6(c) of the Food Stamp Act of 1977 is amended by striking out everything after the first sentence and inserting in lieu thereof the following:

7 USC 2015.

"(1) State agencies that elect to use a system of retrospective accounting in accordance with section 5(f)(2) of this Act shall require certain categories of households to file periodic reports of household circumstances in accordance with standards prescribed by the Secretary. Other State agencies, which have received the approval of the Secretary, may also require such

Ante, p. 358.

categories of households to file periodic reports. Each household that is not required to file such periodic reports on a monthly basis shall be required to report or cause to be reported to the State agency, on a form designed or approved by the Secretary, changes in income or household circumstances which the Secretary deems necessary in order to assure accurate eligibility and benefit determinations.

"(2) Any household required to file a periodic report under paragraph (1) of this subsection shall, (A) if it is eligible to participate and has filed a timely and complete report, receive its allotment, based on the reported information for a given month, within thirty days of the end of that month unless the Secretary determines that a longer period of time is necessary, (B) have available special procedures that permit the filing of the required information in the event all adult members of the household are mentally or physically handicapped or lacking in reading or writing skills to such a degree as to be unable to fill out the required forms, (C) have a reasonable period of time after the close of the month in which to file their reports on forms approved by the Secretary, and (D) be afforded prompt notice of failure to file any report timely or completely, and given a reasonable opportunity to cure that failure (with any applicable time requirements extended accordingly) and to exercise its rights under section 11(e)(10) of this Act.

7 USC 2020.

"(3) Reports required to be filed under paragraph (1) of this subsection shall be considered complete if, in accordance with standards prescribed by the Secretary, they contain sufficient information to enable the State agency to determine household eligibility and allotment levels. All report forms, including those related to periodic reports of circumstances, shall contain a description, in understandable terms in prominent and bold face lettering, of the appropriate civil and criminal provisions dealing with violations of this Act including the prescribed penalties. The reporting requirements contained in paragraph (1) of this subsection shall be the sole such requirements for reporting changes in circumstances for participating households. In promulgating regulations implementing these reporting requirements, the Secretary shall consult with the Secretary of Health and Human Services, and, wherever feasible, households that receive assistance under title IV-A of the Social Security Act and that are required to file comparable reports under that Act shall be provided the opportunity to file reports at the same time for purposes of both Acts.".

Regulations, consultation with Secretary of Health and Human Services. 42 USC 601.

CONFORMING AMENDMENTS FOR RETROSPECTIVE ACCOUNTING AND PERIODIC INCOME REPORTING

7 USC 2012.

SEC. 111. Section 3(c) of the Food Stamp Act of 1977 is amended to read as follows:

"Certification period."

"(c) 'Certification period' means the period for which households shall be eligible to receive authorization cards. For those households that are required to submit periodic reports under section 6(c)(1) of this Act, the certification period shall be at least six months but no longer than twelve months. For households that are not required to submit periodic reports, the certification period shall be determined as follows:

compliance by a State agency of a type specified in this subsection,";

(2) inserting "without good cause" before "to comply";

(3) striking out "or" before "the State plan of operation";

(4) inserting after "section," the following: "or the Secretary's standards for the efficient and effective administration of the program established under section 16(b)(1) of this Act"; and 7 USC 2025.

(5) inserting before the period at the end of the second sentence the following: ", and, whether or not the Secretary refers such matter to the Attorney General, the Secretary shall proceed to withhold from the State such funds authorized under sections 16(a) and 16(c) of this Act as the Secretary determines to be appropriate, subject to administrative and judicial review under section 14 of this Act.". 93 Stat. 391. 7 USC 2025. *Post*, p. 364.

SEC. 121. Section 16(b) of the Food Stamp Act of 1977 is amended by striking out the last sentence thereof. 7 USC 2025.

SOCIAL SECURITY OFFICE APPLICATION

SEC. 122. Section 11(i)(2) of the Food Stamp Act of 1977 is amended by striking out "simplified affidavit" and inserting in lieu thereof "simple application". 7 USC 2020.

SPECIAL FINANCIAL AUDIT REVIEW OF HIGH PARTICIPATION STATES

SEC. 123. Section 11 of the Food Stamp Act of 1977 is amended by adding at the end thereof a new subsection (l) as follows:

"(l) Whenever the ratio of a State's average food stamp participation in any quarter of a fiscal year to the State's total population in that quarter (estimated on the basis of the latest available population estimates as provided by the Department of Commerce, Bureau of the Census, Series P-25, Current Population Reports (or its successor series)) exceeds 60 per centum, the Office of the Inspector General of the Department of Agriculture shall immediately schedule a financial audit review of a sample of project areas within that State, and shall, upon completion of the audit, provide a report to Congress of its findings and recommendations within one hundred and eighty days. Any financial audit review subsequent to the first such review, required under the preceding sentence, shall be conducted at the option of the Office of the Inspector General.".

FORFEITURE OF PROPERTY INVOLVED IN ILLEGAL FOOD STAMP TRANSACTIONS

SEC. 124. Section 15 of the Food Stamp Act of 1977 is amended by adding at the end thereof a new subsection (g) as follows: 7 USC 2024.

"(g) The Secretary may subject to forfeiture and denial of property rights any nonfood items, moneys, negotiable instruments, securities, or other things of value that are furnished or intended to be furnished by any person in exchange for coupons or authorization cards in any manner not authorized by this Act or the regulations issued under this Act. Any forfeiture and disposal of property forfeited under this subsection shall be conducted in accordance with procedures contained in regulations issued by the Secretary.".

ments which are issued in a given period by a State agency to households that fail to meet the eligibility requirements of sections 5 and 6 of this Act, are overissued to eligible households, and are underissued to eligible households; (C) 'national standard payment error rate' means the weighted mean payment error rate for all State agencies; and (D) 'dollar value equivalent' means the value of allotments determined by multiplying a given error rate by the dollar value of all the allotments issued by a State agency during the particular period in question. 7 USC 2014, 2015.

"(3) The Secretary shall conduct a study to determine whether it is feasible to include in the calculation of each State agency's payment error rate, and in the calculation of the national standard payment error rate, invalid decisions by each State agency denying eligibility to households that are in fact eligible. If the Secretary determines that such a change in the method of calculation is feasible, the Secretary shall implement changes in the method of calculating payment error rates for the purposes described in this section. Feasibility study.

"(4) If the Secretary makes a claim against a State for payment under paragraph (1) of this subsection, that State may seek administrative and judicial review of such claim under the procedures set forth in section 14 of this Act. If such claim is ultimately determined to be valid or is not contested by the State, it shall be collected by the Secretary and may be collected through State payment, through withholding amounts otherwise payable to the State agency under subsection (a) of this section, or through other mechanisms authorized by the Federal Claims Collection Act of 1966.". Administrative and judicial review. 7 USC 2023. 31 USC 951 note.

DISCLOSURE PROVISIONS

SEC. 127. (a)(1) Subsection (i) of section 6103 of the Internal Revenue Code of 1954 (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end thereof the following new paragraph: 26 USC 6103.

"(7) DISCLOSURE OF CERTAIN RETURN INFORMATION BY SOCIAL SECURITY ADMINISTRATION TO DEPARTMENT OF AGRICULTURE AND TO STATE FOOD STAMP AGENCIES.—

"(A) IN GENERAL.—The Commissioner of Social Security may disclose return information from returns with respect to net earnings from self-employment (as defined in section 1402), wages (as defined in section 3121(a) or 3401(a)), and payments of retirement income which have been disclosed to the Social Security Administration as provided by paragraph (1) or (5) of this subsection— 26 USC 1402, 3121, 3401.

"(i) upon request, to officers and employees of the Department of Agriculture, and

"(ii) upon written request, to officers and employees of a State food stamp agency.

"(B) RESTRICTION ON DISCLOSURE.—The Commissioner of Social Security shall disclose return information under subparagraph (A) only for purposes of, and to the extent necessary in, determining an individual's eligibility for benefits, or the amounts of benefits, under the food stamp program established under the Food Stamp Act of 1977. 7 USC 2011 note.

"(C) STATE FOOD STAMP AGENCY.—For purposes of this paragraph, the term 'State food stamp agency' means any agency described in section 3(n)(1) of the Food Stamp Act of

7 USC 2012.

1977 which administers the food stamp program established under such Act.".

26 USC 6103.

(2)(A) Subparagraph (A) of section 6103(p)(3) of such Code (relating to records of inspection and disclosure) is amended by striking out "(l)(1) or (4)(B) or (5)" and inserting in lieu thereof "(l)(1), (4)(B), (5), or (7)".

(B) Paragraph (4) of section 6103(p) of such Code (relating to safeguards) is amended by striking out "(l)(3) or (6)" in so much of such paragraph as precedes subparagraph (A) thereof and inserting in lieu thereof "(l)(3), (6), or (7)".

(C) Clause (i) of section 6103(p)(4)(F) of such Code is amended by striking out "(l)(6)" and inserting in lieu thereof "(l)(6) or (7)".

26 USC 7213.

(D) The first sentence of paragraph (2) of section 7213(a) of such Code is amended—

(i) by striking out "or any educational institution" and inserting in lieu thereof "any educational institution, or any State food stamp agency (as defined in section 6103(l)(7)(C))", and

(ii) by striking out "subsection (d), (l)(6), or (m)(4)(B)" and inserting in lieu thereof "subsection (d), (l)(6) or (7), or (m)(4)(B)".

Effective date. 26 USC 6103 note.

(3) The amendments made by this subsection shall take effect on the date of the enactment of this Act.

42 USC 503.

(b)(1) Section 303 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(d)(1) The State agency charged with the administration of the State law—

"(A) shall disclose, upon request and on a reimbursable basis, to officers and employees of the Department of Agriculture and to officers or employees of any State food stamp agency any of the following information contained in the records of such State agency—

"(i) wage information,

"(ii) whether an individual is receiving, has received, or has made application for, unemployment compensation, and the amount of any such compensation being received (or to be received) by such individual,

"(iii) the current (or most recent) home address of such individual, and

"(iv) whether an individual has refused an offer of employment and, if so, a description of the employment so offered and the terms, conditions, and rate of pay therefor, and

"(B) shall establish such safeguards as are necessary (as determined by the Secretary of Labor in regulations) to insure that information disclosed under subparagraph (A) is used only for purposes of determining an individual's eligibility for benefits, or the amount of benefits, under the food stamp program established under the Food Stamp Act of 1977.

Notification to State agency.

"(2) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State.

"State food stamp agency."

"(3) For purposes of this subsection, the term 'State food stamp agency' means any agency described in section 3(n)(1) of the Food

Stamp Act of 1977 which administers the food stamp program established under such Act.". 7 USC 2012.

(2) Paragraph (2) of section 304(a) of the Social Security Act is amended by striking out "subsection (b) or (c)" and inserting in lieu thereof "subsection (b), (c), or (d)". 42 USC 504.

(3) The amendments made by this subsection shall take effect on January 1, 1983. Effective date. 42 USC 503 note.

PAYMENT OF CERTAIN LEGAL FEES

SEC. 128. Section 16 of the Food Stamp Act of 1977, as amended by section 126 of this Act, is amended by adding at the end thereof a new subsection (h) as follows: 7 USC 2025.

"(h) Notwithstanding any other provision of law, counsel may be employed and counsel fees, court costs, bail, and other expenses incidental to the defense of officers and employees of the Department of Agriculture may be paid in judicial or administrative proceedings to which such officers and employees have been made parties and that arise directly out of their performance of duties under this Act; and".

COST SHARING FOR COMPUTERIZATION

SEC. 129. Section 16 of the Food Stamp Act of 1977, as amended by section 128 of this Act, is amended by adding at the end thereof a new subsection (i) as follows:

"(i) Effective October 1, 1980, the Secretary is authorized to pay to each State agency an amount equal to—

"75 per centum of the costs incurred by the State agency in the planning, design, development, or installation of automatic data processing and information retrieval systems that the Secretary determines (1) will assist in meeting the requirements of this Act, (2) meet such conditions as the Secretary prescribes, (3) are likely to provide more efficient and effective administration of the food stamp program, and (4) will be compatible with other such systems used in the administration of State plans under the Aid to Families with Dependent Children Program under title IV of the Social Security Act: *Provided,* That there shall be no such payments to the extent that a State agency is reimbursed for such costs under any other Federal program or uses such systems for purposes not connected with the food stamp program: *Provided further,* That any costs matched under this subsection shall be excluded in determining the State agency's administrative costs under any other subsection of this section.". 42 USC 601.

CONTINUATION OF CASH-OUT PILOT PROJECTS

SEC. 130. Section 17(b)(1) of the Food Stamp Act of 1977 is amended by adding at the end thereof a new sentence as follows: "Any pilot or experimental project implemented under this paragraph involving the payment of the value of allotments in the form of cash to eligible households shall be continued until October 1, 1981, if the State so requests.". 7 USC 2026.

WORKFARE JOB-SEARCH TIME PERIOD

SEC. 131. Section 17(b)(2) of the Food Stamp Act of 1977, as amended, is amended by adding after the phrase "thirty days" in the second sentence the following: "(ten days in at least one pilot project area designated by the Secretary)". *Post*, p. 368.

ADJUSTMENT OF POVERTY GUIDELINES

7 USC 2014

SEC. 137. Section 5(c) of the Food Stamp Act of 1977 is amended by striking out everything after "forty-eight contiguous States" and inserting a period in lieu thereof.

REDUCTION IN ASSETS LIMITATIONS

SEC. 138. Section 5(g) of the Food Stamp Act of 1977 is amended by striking out "$1,750" and inserting in lieu thereof "$1,500".

RESTRICTION ON STUDENT PARTICIPATION

7 USC 2015.

SEC. 139. Section 6(e) of the Food Stamp Act of 1977 is amended by striking out everything after "(1)" and inserting in lieu thereof the following: "is physically and mentally fit and is between the ages of eighteen and sixty, (2) is enrolled at least half time in an institution of higher education, and (3)(A) is not employed a minimum of twenty hours per week or does not participate in a federally financed work study program during the regular school year or (B) is not the head of a household (or spouse of such head) containing one or more other persons who are dependents of that individual because he or she supplies more than half of their support, or (C) is not so enrolled as a result of participation in the work incentive program under title IV of the Social Security Act, as amended (42 U.S.C. 602).".

SEC. 140. Section 6(d) of the Food Stamp Act of 1977 is amended by striking out everything after "person" in the parenthesis in clause (D) of paragraph (2) and inserting in lieu thereof the following: "enrolled in an institution of higher education shall be ineligible to participate in the food stamp program unless he or she meets the requirements of subsection (e) of this section)".

TITLE II—FOOD STAMP FUNDING

APPROPRIATIONS CEILING

93 Stat. 389.
7 USC 2027.
Ante, p. 368.

SEC. 201. The first sentence of section 18(a) of the Food Stamp Act of 1977 is amended by—

(1) striking out "$6,188,600,000" and inserting "$9,491,000,000" in lieu thereof; and

(2) striking out "$6,235,900,000" and inserting "$9,739,276,000" in lieu thereof.

Approved May 26, 1980.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 96-788 accompanying H.R. 4303 (Comm. on Agriculture) and No. 96-957 (Comm. of Conference).

SENATE REPORTS: No. 96-236 (Agriculture, Nutrition, and Forestry) and No. 96-704 (Comm. of Conference).

CONGRESSIONAL RECORD:

Vol. 125 (1979): July 23, considered and passed Senate (language later inserted in H.R. 4057).

Vol. 126 (1980): May 7, committee amendment in the nature of a substitute considered as an original bill.
May 8, considered and passed House, amended.
May 14, Senate agreed to conference report.
May 15, House agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS:

Vol. 16, No. 22 (1980): May 27, Presidential statement.

○

96TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
No. 96-788

FOOD STAMP ACT AMENDMENTS OF 1980

REPORT

together with

SUPPLEMENTAL VIEWS, DISSENTING VIEWS, ADDITIONAL DISSENTING VIEWS, AND SEPARATE VIEWS

AND

Including Congressional Budget Office Cost Estimate

ON

S. 1309

A BILL TO INCREASE THE FISCAL YEAR 1979 AUTHORIZATION FOR APPROPRIATIONS FOR THE FOOD STAMP PROGRAM

FEBRUARY 27, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

149

96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 96-788

FOOD STAMP ACT AMENDMENTS OF 1980

FEBRUARY 27, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. FOLEY, from the Committee on Agriculture, submitted the following

REPORT

together with

SUPPLEMENTAL VIEWS, DISSENTING VIEWS, ADDITIONAL, DISSENTING VIEWS, AND SEPARATE VIEWS

[To accompany S. 1309]

[Including Congressional Budget Office cost estimate]

The Committee on Agriculture, to whom was referred the bill (S. 1309), to increase the fiscal year 1979 authorization for appropriations for the food stamp program, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

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I. COMMITTEE AMENDMENTS

The amendments are as follows:

Page 1, line 3, strike out all after the enacting clause and insert in lieu thereof the following:

That this Act may be cited as the "Food Stamp Act Amendments of 1980"

TITLE I—REDUCTION IN FOOD STAMP ERROR AND FRAUD AND REVISION OF DEDUCTIONS

MEALS IN SHELTERS FOR BATTERED WOMEN AND CHILDREN

SEC. 101. (a) Section 3 of the Food Stamp Act of 1977, as amended, is amended by—

striking out in clause (1) of subsection (g) "and (7)" and inserting in lieu thereof "(7) and (8)";

error rate from the two six-month quality control periods of a fiscal year and comparing the result to the State's average payment error rate for the two equivalent quality control periods during the previous fiscal year.

HEW currently has a reward system in effect that it finally established on November 26, 1979, pursuant to which, for each one-half percent that a State reduces its payment error rate below four percent, the State would receive 10 percent of the money saved, while States that reduce dollar error rates to below two percent, would get 50 percent of the Federal savings. But HEW's system is quite unrealistic because most State error rates are currently higher than four percent, resulting in few incentive payments. This Committee's incentives are designed to work and actually to benefit some States. Hawaii appears to be in striking distance of 65 percent cost-sharing based upon the latest available quality control data, which are from the pre-1977 Act implementation period of January through June, 1978 and reveal Hawaii to be at the 5.6 percent mark while Nevada would already qualify at 0.7 percent. Idaho (8.0), North Dakota (6.1), Oklahoma (7.5), Washington (7.3) and Wyoming (6.1) could all obtain 60 percent were they to maintain these good error rate records through to the onset of the new system in fiscal year 1981.

3. RETROSPECTIVE ACCOUNTING

In section 5(f) of the Food Stamp Act of 1977, the Congress adopted a hybrid method of income accounting for purposes of determining the eligibility of a household to receive food stamps during a certification period and the value of the allotment the household is entitled to receive. The hybrid stressed the concept of "income that is and will be actually available to the household" for the relevant certification period, but did so by balancing, but not averaging both income received in the past and income anticipated for the future in an effort accurately and reasonably to predict income that would be available in the future. The Committee's Report, House Report No. 95-464, 95th Cong., 1st Sess., pp. 76-77, contains a thorough discussion of the matter and should be included here, both because it helps to explain by contrast the opportunity to utilize an alternative method of income accounting contained in this bill and because it will presumably remain the method of income accounting employed by a significant majority of States until such time as it is replaced by retrospective accounting through the process of State election:

a. Committee action

In the Committee hearings in 1976 only two witnesses favored 30-day retrospective accounting in order to eliminate from the program the temporarily unemployed and strikers, while two others supported 30 days' retrospective with speed-up for the recently unemployed and forty-eight witnesses sought the use of current or anticipated income. In 1977, all witnesses were basically in favor of the Committee version of the accounting period.

The Committee bill makes "the income reasonably anticipated to be received * * * in the certification period for which eligibility is being determined and the income which has been received by the

household during the thirty days preceding the filing of its application for food stamps so that the State agency may reasonably ascertain the income that is and will be actually available to the household for the certification period."

The Committee rejected by a show of hands vote of 6 to 12 a thirty-day retrospective amendment similar to the one contained in the Senate food stamp bill in 1976 because of provisions for immediate application (although entailing a thirty-day wait for receipt of food stamps for households suffering a substantial loss of income).

The resulting Committee standard of reasonable ascertainment of actually available income approach is a flexible accounting concept, with the certifier bound by the specific goal of ascertaining as best as possible the income that is and will be actually available to the household.

Income in hand, not in the bush, is what must be counted. Income available, and, thus, usable to purchase food is the key criterion. It is to be determined by the certifier by looking to two periods of time. The first is the past 30 days ("past" in the sense of preceding the filing of an application for participation), not to calculate what funds received during that period might remain in fact available for food in the certification period of whatever length it may be because such funds would constitute assets in the later period following their receipt rather than income, but solely to find out whether the income actually received in those 30 days offers a sufficiently strong basis to predict precisely what income would be actually available in the upcoming certification period. The second period of time is the future two weeks or one month or three or six or twelve, depending upon the appropriate certification period. It is the latter that has the priority, since it is income actually available during that period that must be accurately ascertained.

The past is thus not totally excluded from the purview of the certifier, but it is subordinate to the central task of reasonably predicting the future availability of funds. If the prediction proves wrong, it cannot continue to be relied on to set the purchase price. If income previously obtained does not prove available in the future, then however likely its receipt once seemed to be, it must be deleted from the income calculation and appropriate adjustments made in the purchase price. If an item already received has been spent in one month, it cannot properly be attributed by the averaging process to future months, since the applica. household would not have access to it in order to buy its food stamps. Thus, averaging would generally have to yield to the so-called "variable basis of issuance", which more realistically assigns income only to its month of receipt, except for the specific exceptions for annualizing income in the Committee bill.

Since the Committee formally rejected 30-da trospective accounting looking only to income already secured as the basis for calculating purchase price and did not choose to replace the word "take into account" with "average" in describing what accounting was to be performed with respect to the prior 30 days, the flexible accounting concept contained in the Committee will mandates ignoring income received in the past 30 days to the extent it does not accurately depict what will be available to the applicant household in the next certifica-

tion period. For example, the fact that a farm worker managed to secure twenty days of work in the past month cannot be used to saddle him with twenty days of anticipated work income in the month ahead when the predicted work may not materialize.

How does this new legislative approach affect the current regulations and instructions? To begin with, the need to account for deductions would be terminated as the standard deduction plus three relatively-fixed, potential monthly deductions replace the itemization system. Income averaging would become dubious except in those instances in which the bill expressly approves it, since it does not purport to measure actual availability of income, which is more the task of the "variable basis of issuance." The rules on earned and public assistance income would remain in place and the holding of *Gutierrez* would become law—anticipating income is a proper part of the income calculation function in determining household eligibility, but not to the extent that it interferes with finding out what income is or will be actually available. If anticipation does not comport with reality and no income or less income than projected appears, then anticipation must be scrapped and swiftly in favor of operating on the basis of what has occurred. The goal is to smooth the way for anticipation by the needy, not to place obstacles in their path by making them out to be less needy than they in fact are.

The Committee bill would continue the practice of annually averaging income for households that derive their annual income in a period of time shorter than one year, but not on an hourly or piecework basis, such as certain self-employed persons, teachers, and students. The self-employed who receive only bunched-up income squeezed into a few months reflecting activities undertaken over the course of a longer period of time, e.g., one-crop farmers, would be treated as under current instructions, with gross income offset by the cost of production and the remainder averaged over twelve months. For school employees, the Department's present instructions would also continue in force, with their contractual income spread over twelve months or prorated, as the instructions now indicate. That portion of student income that is represented by grants or scholarships used for purposes other than mandatory fees or tuition (the portion used for such purposes would be excluded from income) would be averaged over the number of school term months the funds were intended to cover. Other sums received would then be added in the fashion of current instructions. Farm workers who are paid on an hourly basis or by the bushel would not be subject to such averaging over twelve months, even if their earnings were bunched in a few months of the year.

While the hybrid accounting method contained in the 1977 Act, which will be labeled "prospective" hereafter in contrast with the "retrospective" alternative contained in this bill, was designed to be as fair as possible to applicant households and assure full participation, it has not proven easy to predict available income for the future accurately. Thus, it is possible, although by no means certain that the anticipatory or partially prospective method of accounting may have been responsible, in some instances, for increasing the risk of error. It is admittedly easier to ascertain past income accurately. Indeed, current verification requirements already invite heavy reliance by eligibil-

ity workers and households alike on records of prior months' income and expenses, with documentary evidence proving households' statements consisting of such items as a prior month's wage stubs or rent receipt or utility bill.

Accordingly, since it is certainly worth exploring whether or not a retrospective method of accounting based upon past income will serve to lower quality control error rates, the Committee has decided to allow States to elect, State-by-State, to adopt a retrospective system using income received in a month prior to the month for which a household's eligibility and benefit level are being determined in place of the hybrid described above.

In its 1977 Report, House Report No. 95–464, 95th Cong., 1st Sess., pp. 357–362, this Committee analyzed both retrospective accounting and monthly reporting from a cost-saving point of view and concluded that neither provided a substantial net savings and might even add costs to the program. Interim evidence from experiments conducted by the Department of Health, Education, and Welfare in connection with AFDC and Colorado do not tend to suggest that any substantial cost savings would accrue, and there is even a hint that errors might be higher under retrospective accounting because of the significant administrative disruption implementing its entails. Nevertheless, the Committee now believes that State option is an appproriate route for trying to obtain reduction in error and costs, provided it is conducted under standards fixed by the Secretary, with each State's plan subject to his review and approval.

The Department of Health, Education, and Welfare (HEW) has already adopted elective retrospective budgeting in its Aid to Families with Dependent Children (AFDC) program.

HEW made its prospective budgeting regulations final on May 4, 1979, 44 Federal Register 26075–84, and issued an October 7, 1979, a directive to the States to report by December 31, 1979, their choice of either retrospective or prospective budgeting in AFDC. California, Illinois, Kansas, Michigan, Oregon, and Washington are now employing retrospective budgeting while Utah is actively contemplating using it. How many others will make the final choice still remains uncertain, but the fact that a limited number of States are involved justifies this Committee's decision to allow States the option in the food stamp program as well. Whether there are hesitations about data processing of the accompanying periodic reports or concerns about the actual cost-saving, error-reducing qualities of such a system (HEW still has a variety of experiments in operation to test and compare various combinations of budgeting systems and reporting requirements in Illinois, Massachusetts, Michigan, and New York City), there remains a legitimate basis for State option in this matter of income accounting as the sole statutory exception to the mandate of uniform national standards of eligibility contained in section 5(b) of the Act.

No State would have to elect to utilize one of the two methods in calculating income on a Statewide basis. In order to run an efficient system, a State may determine that it makes sense to operate a monthly retrospective system in some project areas (such as cities), but not in others (such as rural areas) where it may be cost-ineffective. States would have this option. Similarly, in order to promote both efficiency

and coordination with AFDC, a State may wish to use the monthly retrospective system for the AFDC portion of the food stamp caseload, but not for the non-welfare portion of the caseload. States would also have this option if they determined this to be the wisest and most cost-effective choice.

Although the retrospective method of income accounting for which any State may opt is intended to be an alternative to anticipatory or prospective accounting, it, too, is a hybrid in certain respects. There are at least seven instances in which a retrospective system would have to be modified by any State choosing to use it to comply with regulations promulgated by the Secretary.

Perhaps the best way to understand the need for the exemptions is to describe the workings of the system. Assume that a household contains a wage earner who loses his or her job on November 22nd. The head of the household applies for benefits on the 25th of November. Under the current hybrid anticipatory accounting, the household would obtain a November allotment as soon as possible, but within expedited service standards (coupons or authorization card to be mailed no later than the close of business of the second working day following November 25 or to be picked up no later than the start of business of the third such working day). But, under pure retrospective accounting, that allotment would be based on the household's October income, which would be obviously higher than what the household would actually have in hand after the loss of job earnings as of November 22nd. The income derived retrospectively might, indeed, be so high as to render the household ineligible to participate at a time when that household seriously needed an outside boost in its food purchasing power in order to obtain a more nutritious diet and alleviate the prospect of malnutrition (the purposes of the Act) or, at least, high enough substantially to reduce the household's benefits at a time when full benefits were needed. Furthermore, under pure retrospective accounting, the household's January allotment would be based upon income actually received for the month of November, which, under the traditional calendar month approach, would lead to the inclusion in income of a full three weeks of earnings obviously no longer available to the household during January. The patent unfairness of this situation—however accurate the calculation of October and November actual income might be—induced the Committee to mandate the specific exemptions that follow:

(1) *Month of application.*—To determine a newly applying household's eligibility and benefit level for the month of application, the current system of prospective and not retrospective accounting would apply pursuant to the Secretary's required standards. This would mean that a November applicant's eligibility and stamp allotment value, if any, would be calculated in light of its anticipated to be actually available November income and not its September income. The exemption and temporary return to prospectivity would help those who experience a significant reduction of income in the application month and, thus, a meaningful loss of food purchasing power disabling them from spending sufficient cash on top of reduced food stamp benefits to achieve the nutritional value of the Thrifty Food

Plan. In September, such cash might have been available, but certainly not in November after it had already been consumed. For this purpose of supplanting retrospective with prospective accounting, the State could label as the first month any month it ordinarily used as the "month of application".

This initial month existing prospective accounting determination of eligibility and benefits would apply only to a newly applying household and not to an applicant household which had previously been receiving food stamps, but whose benefits were effectively terminated during the same month in which the household reapplied to receive food stamps. Since the termination of benefits was presumably caused by the household's receiving sufficient income in that month to render it ineligible to continue to participate, handling that household's income on a prospective basis could lead to the elimination of considerable income from consideration. Accordingly, to avoid such gaps, the State would compute initial benefits for the initial month on a retrospective basis for such households.

(2) *Subsequent month(s)*.—Where a State electing to utilize retrospective accounting views the first month of application for a newly applying household to be the month in which application is made, e.g. November for a November 25 application, to apply prospective budgeting for November (*i.e.*, calculating November benefits in light of November income) and then to apply retrospective budgeting for December and thereafter (*i.e.*, calculating December benefits in light of October income) would mean that the reduction in income caused by a job loss toward the end of November would not be meaningfully reflected in December's benefits, which would, therefore, be significantly lower than they would be if ascertained on a prospective basis (the aim of the first specific exception) and which would be particularly low at the moment. Thus, unless the second month's income in such a State were required to be dealt with on a prospective basis, the objective of the prospectivity requirement in the first month would be undermined and the household treated harshly and unfairly. To avoid this occurrence, the Secretary is expected to make States that elect retrospectivity, but do not treat the first full month following the date of the month of application as the month of application for initial prospectivity, employ prospectivity not only in the month of application, but in the subsequent month(s) as well. It is for these reasons that the bill specifies that income from a previous month is not to be used during the month of application or succeeding months as appropriate. This is necessary to allow a household applying after suffering an income loss to participate when it most needs benefits, rather than requiring the household to wait one or two months. For example, if a wage earner was paid off in late November and retrospective accounting was quickly put into effect, the household's December and January benefits could be heavily determined by income received before the lay-off, even though the household no longer had any income. The bill avoids this hardship of denying benefits in the face of legitimate need. No income earned prior to the date of application could be counted in any month subsequent to the month of application. To achieve this, the Secretary must use prospective accounting in the month of application and subsequent months as necessary.

If, retrospectively, it turned out that the household income was higher or lower than anticipated for these prospective months, neither claims nor retrospective benefits should be in order, unless, of course, there was an over-issuance due to a household's failure to meet a reporting requirement or an underissuance due to a State agency failure to act as required on a reported change.

(3) *Sudden and significant loss of income.*—Rigorous retrospectivity would similarly not apply by virtue of regulation in order to avoid a hardship whenever a household experienced a sudden and significant loss of income, such as one attributable to loss of a job, termination of general assistance or unemployment compensation benefits, or desertion of a spouse, even if the household were already receiving food stamps (a household newly applying for food stamps because of such an income loss would be aided as well by the first two exceptions). Retrospectivity in accounting could not apply on a pure basis whenever the loss of income amounted to $50 per month or more, although the Secretary would retain the authority to make exceptions to or modifications of retrospectivity in special circumstances involving lesser income losses that presented potential hardship in light of household size or other classes of factors. Fifty dollars a month would remain an automatic trigger for the application of an exception at all times, but smaller amounts might suffice as a trigger point in accordance with regulations because of their percentage impact upon a household's monthly income. The Secretary's tests for the suddenness or significance of a loss could not be higher than $50 a month, and no State could vary the Secretary's definitions of suddenness or significance.

As part of the modifications or exceptions approach that the Secretary must promulgate through regulations, the Secretary would have to provide for the use of supplemental food stamp benefits or special procedures that would have the equivalent impact of aiding the needy when need is most intense in all States with a retrospective system. HEW's welfare regulations already contain provision for supplemental payments under a retrospective method of accounting that call for such payments, were applicable, to be made for the month in which they are requested and to be issued within five working days of such request. 45 C.F.R. § 233.27(a).

Food stamp supplementals, like welfare supplementals, should be paid for the month in which requested and not an earlier month. The level of the supplemental food stamp payments would be the full food stamp benefit for which the affected household was eligible based upon its actual income circumstances rather than its prior income situation, which means excluding from the "income available" calculation, for purposes of measuring the supplemental, all regularly excluded income and deductions and applying the same definition of income and resources as is normally used.

The Secretary's regulations on the nature of the loss and the methods to redress it should be as fair to participating households and as easy to administer by the States as possible. States would be required to inform households in writing of the availability of supplemental payments if circumstances change, the circumstances under which they are paid, the method(s) for calculating them, and how to report these

changes. Such a notice could well be made part of the periodic reporting forms distributed to households that are an accompanying feature of retrospective budgeting. A description of this procedure should also be included in basic program materials. Households would not need to make a special request for a supplemental payment. The payment would be automatic once the food stamp office became aware of a change triggering eligibility for such a payment.

(4) *Addition of a new member.*—The same modification or exception rules, complete with provision for appropriate supplemental payments, should apply to the addition of a new household member by way of birth or movement into the home or the joining in food purchase and preparation of a person or persons already living in the home, but previously dealing with meals on a separate basis from the existing food stamp household. The Secretary should mandate supplemental payments to take immediate account of the enlarged allotment attendant upon the addition of one or more household members.

(5) *Immediate need.*—Effective modifications or exceptions designed to avoid hardship, including supplemental payments, if the Secretary deems them advisable, would have to be provided for in the regulations to cover persons eligible for expedited service under section 11(e)(9) of the Act because of their immediate need as defined in 7 C.F.R. §§ 273.2 (i)(1)(i) and (ii) and 7 C.F.R. § 273.10(e)(3). This would encompass not only households whose only income for a month was from a terminated source (who might be taken care of under the third specific exemption from pure retrospectivity), but also households whose only income is from a new source and is less than $25 or from both a terminated and new source but less than $25.

(6) *Migrant farmworker households.*—Regardless of the status of their application (new or continuing) or the existence or level of any income loss or of the presence or absence of any of the other factors triggering exemption from retrospective budgeting and the provision of exceptions or modifications, including supplemental payments, applicant or participating migrant farmworker households would be automatically eligible for initial month(s) prospectivity and whatever form exceptions or modifications to retrospectively take for other types of households. The fundamental principles of retrospectivity simply do not work for the migrant farmworker households while they are in the migrant stream (they would not be deemed to be "migrant" for accounting purposes during those months of the year in which they are living at their home base States). It would be difficult indeed to link reports of migrant income filed in October in State X with an application for food stamp benefits in State Y many miles away in December. Given the difficulty if not impossibility of tracking these reports and matching the systems up as well as the numerous fluctuations in fortune to which such farmworkers are inordinately subject, such as unexpected changes in the weather, crop cycles, and grower decisions to alter employment orders, prospectivity or some other non-retrospective accounting system will have to govern the determination of the eligibility and benefits of "in stream" migrants.

In administering the current hybrid system of accounting in States not electing retrospective budgeting as it applies to migrant farm-

worker households or the exceptions or modifications to retrospective budgeting in electing States, the States must be particularly careful to avoid the all-too-prevalent abuses of the statutory concept of income "reasonably anticipated to be received." This Committee has been informed through testimony of numerous instances in which local food stamp certification officers have sought to determine the availability of farm work in an area by questioning local growers and, upon receiving a favorable response, assigned appropriate wage rates to these phantom potential jobs for purposes of attributing that income to an applicant or recipient farmworker household in this case (whether migrant or seasonal). The availability of a job paying $X is not the same as the guaranteed receipt of such income such that it qualifies under the actual availability test. Anticipation of income with regard to farmworkers has to be handled cautiously because of the numerous occasions on which it does not comport with reality and no income or less income than that which was anticipated be received is obtained by the household. The Committee expects the Secretary to take appropriate steps to monitor compliance with this statutory test of reasonable anticipation and reasonable ascertainment of "income that is and will be actually available to the household for the certification period."

(7) *Catch-all.*—The Committee, with its list of six specific exemptions from pure retrospective budgeting does not intend to limit the Secretary's discretion by way of regulation to expand the modifications or exceptions to this method of income calculation to encompass other specific economic groups or classes of situations or circumstances, however small and isolated, that he deems to be appropriate for such exemption because to apply retrospective budgeting to them in a rigorous fashion would either be impracticable from an administrative point of view or would lead to serious hardship in the form of diminished food purchasing power in a time of actual need. For example, retrospective accounting and monthly reporting would not apply to persons who, by contract or self-employment, derive their annual earnings in less than a year. Such persons, including farmers or teachers who are paid over nine months instead of twelve, would continue to have their income treated as under current regulations. Student scholarships and grants would continue to be treated as under current regulations.

Other self-employed persons who do earn income each month also present significant difficulties for the retrospective system. Requiring a report each month of gross income, expenses, etc., would be highly burdensome to food stamp offices, as well as to the rest of the caseload who would find the length of the report form expanded to include these questions. The system is likely to prove impractical for such persons. Their self-employment is best handled by the maintenance of current procedures.

The Secretary will also need to design special procedures for dealing with recurring lump sum income that occurs on other than a monthly basis.

Finally, to help keep the retrospective system as current as possible, household circumstances used for matters other than income should be the household's circumstances as of the end of the budget month.

Where feasible the retrospective system should be operated in a fashion to promote coordination with retrospective budgeting under AFDC. Nevertheless, this may not be done at the expense of meeting the requirements contained in the Act or this report and may not be done in such a fashion as to undermine the basic principle of national uniformity in the food stamp program in other respects. For example, there would be no change in food stamp income or assets exclusions prescribed in section 5 of the Act, nor any change in the expedited service requirements prescribed by section 11(e)(9) of the Act.

4. PERIODIC REPORTING

An inevitable concomitant of retrospective accounting is a system of periodic reporting of household circumstances. The committee, which, in 1977, inserted in the act a reporting requirement that only covered certain changes in income or household circumstances deemed necessary by the Secretary to assure accurate eligibility and benefit determinations rather than all such circumstances, section 6(c), has decided to expand that reporting requirement in light of the advent of retrospective accounting and the need for more timely, regular information to minimize errors. The new mandate to report would embrace periodic reports of all circumstances by special categories of households determined by the Secretary in States that elect to implement retrospective budgeting, if the States decided to require the filing of such reports.

Although retrospective accounting and periodic (mostly monthly) reporting constitute separate sections of the bill, they actually are designed to operate together as a system. This system must function in accordance with standards prescribed by the Secretary. While periodic-retrospective systems may be able to reduce errors if run properly, they may also adversely harm households, unnecessarily increase administrative costs, and possibly increase errors if handled poorly. It is essential, therefore, that States receive prior approval from the Secretary for a periodic-retrospective system that meets the Secretary's standards, before the State begins to operate such a system.

Despite the underlying requirement of national uniformity in eligibility criteria that governs factors of disqualification, the committee would also extend the option to impose periodic reporting on the same household categories to any State that so desires in accordance with the Secretary's standards, even if such a State budgets prospectively. Finally, every other household not covered by the new periodic reporting requirement (at State election—either of retrospective budgeting or of periodic reporting per se) would be subject to the existing "changes only" reporting regulations, 7 C.F.R. § 273.12, unless the changes to be reported were already included in a non-monthly periodic report.

The current requirements for reporting forms—that they be designed or approved by the Secretary and contain, in prominent and bold face lettering, an understandable description of the act's civil and criminal provisions and penalties—would continue to be applicable to all forms required under the revised act, whether periodic or not. While States could choose to obtain some periodic reports either by opting

for retrospective budgeting or, despite retaining prospective accounting, by obtaining the Secretary's approval for requiring such reports from the same categories of households subject to periodic reporting in retrospective budgeting States, they could not impose any other participating households. That power continues to be denied to them in a uniform system. The Secretary would retain his unqualified authority to approve the categories of households required to report periodically to any State, to approve the periods for which such reports would be required, to permit or not to permit prospective budgeting States to require the same reports from the same categories of households, to design or approve all reporting forms in accordance with the minimal statutory specifications and any further information he chooses to include, and to impose any other requirements upon administration of a periodic reporting system that he deems advisable to protect program integrity and /or to provide for household need.

The Secretary's decision to allow a State employing the current income accounting method to operate a periodic reporting system should be predicated upon his considered conclusion that the State can meet the minimum standards set forth below and run an efficient system without harming eligible households. The Secretary should be guided in his determinations as to the coverage and frequency of periodic reporting in retrospective accounting and approved hybrid prospective accounting States by the Committee's desire to have eligibility and benefit levels reflect actual household circumstances as quickly and accurately as possible and, at the same time, to minimize the burdensome flow of paper which could well prove more hindrance than help in cutting costs and reducing error.

Accordingly, the Secretary would be expected to require only those households whose circumstances that affect eligibility or benefit levels are likely to change to submit periodic reports. He would specifically exclude from such a requirement households consisting entirely of unemployable or disabled or elderly persons, who have very stable income and the likelihood of stability as well in such factors as deductions and household composition. Thus, SSI or social security beneficiaries or recipients of pensions would be exempt from periodic reporting.

Similarly, non-elderly households ought not to have to report periodically if they had either long-term, stable or readily predictable earned income or no earned income but stable unearned income and, in either event, relatively fixed deductions in households of relatively fixed size. The categories of households exempt from periodic reporting should include, at a minimum, the types of households eligible for certification periods of six months or more under section 3(c) of the Act and 8 C.F.R. § 273.10(f)(4)–(6), residents of drug or alcoholic treatment centers, and migrant farmworkers. The goal should be to exempt as many categories of households as possible from periodic reporting consistent with reducing the prospects of error in eligibility and benefit determination. For purposes of conformity with the AFDC program and administrative efficiency, States should be able to elect to cover only the AFDC portion of their food stamp caseload in their periodic reporting system.

The normal reporting period for those required to report should be monthly, as in the tests now being conducted by HEW and in regular

program administration in nearly ten States. See 45 C.F.R. § 233.28. Reports on a less frequent basis, perhaps bimonthly or quarterly, should apply to those households subject to some, but not frequent, significant changes in income or household status. In any event, the periods assigned or approved by the Secretary should parallel those utilized by HEW for comparable categories of households, wherever feasible, to assure compatible reporting systems between AFDC and food stamps. If any household is required to submit periodic reports less often than monthly, it would be required to comply as well with the existing requirement on reporting changes as they occur so long as the changes did not take place in the month in which the regular periodic report was mandated.

Perhaps the most critical component of this new periodic reporting requirement is the development of clear, reasonable, and consistently applied rules as to the content and completeness of the reports, the timeliness of their filing, the aid and protections to be offered households ill-equipped to deal with such a system, the State's responsive treatment of the reports in providing allotments, and the procedures for handling benefits in the face of failure fully to comply with the governing periodic reporting requirements.

The committee contemplates that the reporting forms would be focused on requesting only that information needed to determine if a change in income, deductions, or circumstances affecting the fact or level of participation had occurred and, further, that such forms would be couched in simple, comprehensible English, with appropriate bilingual forms where bilingual certification materials are required pursuant to 7 C.F.R. § 272.4(c)(3).

The Secretary is expected to establish standards that would specify the minimum information to be included on the report form limit the additional information that may be included on the form, set forth the documentation (if any) required to accompany the form, and mandate the explanatory material to be provided. The form should not seek information on unnecessary items, such as excluded income, excluded resources, or resource changes within $1,750. The goal must be to keep the form as short and simple as possible. Studies have demonstrated that complex forms which recipients cannot understand are a significant cause of error in public assistance programs.

The forms themselves should explain precisely what information must be reported as well as the applicable verification requirements calling for the accompanying submission of documents. It is critically important that the system be explained as clearly as possible to applicant and participating households to assure that the confusion inevitably attendant upon such an inundation of forms and paperwork does not result in unjust denial or delay of benefits legitimately due.

As is the case with monthly report forms in public assistance under 45 C.F.R. 233.28(a), the food stamp monthly report forms should specify the date by which the State must receive the form and the consequences of a late or incomplete form (including the potential for the State's delaying or withholding benefits for a late form); should identify the person or persons or office that a recipient household should contact to receive prompt answers to questions about informa-

tion requested on the form (including a telephone number for this purpose); should include a statement for the household's signature indicating that the household understands that the information it is providing could result in benefit changes, including reduction or termination; should advise the household when supplemental stamps would be available and the proper procedures for initiating a request for such stamps; and should advise the household of its right to request and receive a fair hearing on any decrease or termination of benefits or any denial of supplemental benefits.

The reports should be considered complete if they are signed and contain sufficient information to enable certification officials to determine the household's eligibility and allotment value. The Secretary shall establish standards for completeness. Thus, submitted forms should not be rejected and benefits terminated or reduced because the report does not have the address of the sender from whom it was mailed or has one or more blank spaces, when the missing information has no potential impact whatever on eligibility or benefit levels. HEW applies a similar rule in connection with the completeness of AFDC monthly reports, 45 C.F.R. 233.28(c). The Secretary should develop regulations that require States to act affirmatively to assist households that miss the filing date or file an incomplete report because they have difficulty understanding or dealing with the form. This would enable reports with missing or insufficient verification to be treated as complete, subject, of course, to recovery of overpayments, in order to avoid a delay in the receipt of benefits when complete verification could not be obtained in time. The exceedingly tight time frame between receipt of the report and disbursement of benefits (inevitably considerably less than 30 and, more likely, 20 days) renders stringent enforcement of a verification reporting requirement exceedingly burdensome to a recipient household whose eligibility has, until the report, already been verified in accordance with regulations as of original certification. Thus, no form should be judged incomplete for failure to furnish supporting documentation, unless the State has other evidence that the data provided in the form by the household are so incorrect as to affect eligibility of benefits.

States must also establish procedures to deal with households whose report is incomplete or raises questions. Such households must not be allowed to fall through the cracks or have benefits delayed. States should be required to act promptly when questions are raised by a form.

The reports should be deemed to be timely filed so long as they are submitted and received by the State within a reasonable period of time (10 days should qualify) from the date the report form was first mailed to the participating household or the end of the month covered by the report, whichever is later, with the State to record the date of the report's receipt. Every recipient household would have to await the end of the month before completing the form, so tolling the running of any time limit at least until then is critical. As long as 10 days for completion of the form, mailing, and receipt appears to be reasonable under most circumstances. Where delay is related to postal delay (unusual gap between postmark and the recorded date of receipt) or the particular recipient household's temporary illness or need for help

in filling out the form in accordance with the mandated special procedures for handling filings by those personally unable to fill out the forms, the mandatory 10-day extension period on the deadline discussed below should suffice to remedy the delay problem.

To insure the prompt return of reports the Committee directs the Secretary to furnish recipient households with postage prepaid addressed envelopes together with the requisite forms sufficiently in advance of the requisite reporting date to permit timely compliance. HEW requires States to provide a stamped self-addressed envelope for use by each AFDC recipient in returning each AFDC monthly report. 45 C.F.R. 233.28(d).

The Secretary would be required to promulgate regulations setting forth special procedures that the States must adopt to aid recipient households ill-equipped to submit periodic reports on their own because all adult members are illiterate or less than illiterate, but insufficiently trained in reading or writing skills to understand and respond to the form, or mentally or physically handicapped in such a way as to be unable successfully to cope with the form. Such households should be identified as of the time of initial application and specially dealt with thereafter by way of providing them with appropriate help to assure the availability of the requisite information from them. Such procedures could include resort to authorized representatives or home visits or telephone calls in lieu of a report. Again, the point of requiring a form is not to place another hurdle in the path of participation by eligible households, but to reduce erroneous eligibility determinations and under- or overissuances. The committee wants the Secretary to assure that the States take maximum efforts to prevent any household from having its benefits terminated or reduced because of its inability, rather than its unwillingness, to prepare and file the requisite reports. HEW already follows such an approach with AFDC monthly reporting. 45 C.F.R. 233.28(e).

Each State would have to furnish every reporting household with its allotment revised (or not, if unnecessary) to reflect the reported information within 30 days of the close of the month covered by that report, although the Secretary could promulgate standards in the form of regulations for extending that date of allotment receipt beyond 30 days when necessary to accommodate late recipient filing or other objective administrative factors other than State inefficiency in report processing. A determination of administrative necessity in a particular State for noncompliance with the 30-day standard should be made on narrow grounds, such as the need to stagger authorization to purchase card mailings in an urban area. This provision should serve to keep the time gap between the household's circumstances and receipt of the allotment reflecting those (new) circumstances as short as possible. This prompt processing standard would, if properly observed and enforced, help alleviate the potential problem of an overlap between the date of eligibility notification and the date for monthly reporting such that a monthly reporting household would have to file a report before it knew whether or not it was eligible in the first place. Indeed, no monthly report could be sent to any initially applying household any earlier than the date on which the notice of their eligibility was sent.

When the timely, completed report resulted in no change in the household's benefit status, the State would be expected to provide benefits in accordance with the usual processing standards, and when the report resulted in any change in eligibility or benefit levels, to notify the recipient household of the changes and the reasons for them in accordance with the existing notice requirements, with such notice received no later than receipts of benefits, if any.

Finally, the Secretary would have to establish regulations setting forth a particular household's procedural protections in the periodic reporting system should it fail fully to comply with applicable reporting requirements. Each State would have to furnish all households subject to the reporting requirement with a prompt notice of any failure to satisfy that requirement whether because the filed report was allegedly incomplete or late.

Nor, as indicated above, could notice even be dispensed with when a timely, complete report is filed. The monthly report form could not be viewed as tantamount to a waiver of any notice rights and acquiescence in termination or reduction of benefits in light of the information furnished in the form. Recipients are rarely fully aware of the precise consequences on their benefits and participation of all of the information they supply on a form and should not be pressured into signing any waiver of adjustments based upon such information. Because of the lack of full understanding and the fact that the States often misapply such information, the mere filing of the form should not be construed to be a waiver of adequate and timely notice.

Whatever notice is sent would have to meet the standards of timeliness and adequacy contained in 7 C.F.R. § 273(13)(a) and applicable to all adverse action. In addition, notification either that the report was not forthcoming on time (or at all) or was deficient when filed would have to be received by the household 10 days before the expected benefits receipt date (or on or before such date if the State's original filing deadline were within 10 days of that expected benefits receipt date) and would further have to extend an opportunity to the affected household to cure either defect by filing a satisfactory report within an extended period of at least 10 days, with an accompanying warning that termination could result from failure to meet the new deadline. During that extension period, no adverse action could be taken by the State, but if the affected household responded fully and or in time, the defect would be treated as cured and benefit determination would proceed as promptly as possible in accordance with standards set by the Secretary. This provision demanding notice of failure to report followed by adequate extended opportunity to report will help assure that households are not automatically terminated when circumstances beyond their control prevented them from submitting their reports on time or a misunderstanding of the report form prevented them from completing all necessary items on the form.

After the extension period ends and no report or a still insufficient report is received, the State may, if it chooses, terminate food stamp benefits to the negligent household so long as it sends an adequate notice of termination. Although termination could take effect immediately, the affected household could request a fair hearing and continuation of benefits within the allotted ten days of the notice, as

under 7 C.F.R. § 273.15(k), at which point the household's prior level of benefits (before the notice of adverse action) would be reinstated immediately and continued until the unsuccessful conclusion of the hearing or until the expiration of the household's certification period (now to be extended to from six to twelve months for households subject to periodic reporting) without certification as under 7 C.F.R. §§ 273.14(q) and 273.15(k). The bill does, however, permit the Secretary to modify the standards for filing an application for recertification where administratively necessary to handle this provision.

States must establish procedures for promptly reinstating households that fail to submit the report in a timely manner, but then do eventually submit it by the end of the month following the budget month. Such households should not be required to begin a complete, new application process with up to a 30-day wait for benefits. States must develop systematic methods for prompt reinstatement of such households.

In the event that a timely and complete report is field by a reporting household that leads the State to reduce or terminate benefits in light of the information furnished in the report, a regular notice of adverse action would have to be given by the regular 10-day period for requesting a hearing and triggering immediate benefit continuation up to the end of the applicable certification period or the hearing decision, whichever occurs first.

The regulations should also take account of special circumstances affecting the consequences of reporting. If a household loses AFDC eligibility as a result of a monthly report, but is still eligible for food stamps, it may not be terminated from the program and told to reapply. The household must be continuously maintained on the food stamp program as long as it remains eligible.

In a small number of circumstances, information may be provided from a third party which is adverse to the household but cannot be verified in time to meet a 10-day adverse notice requirement before the benefit delivery date. In the Colorado monthly reporting experiment, action on such information was deferred until the following month to avoid compromising due process protections. The Secretary is expected to establish this as a national procedure in the food stamp program.

The committee wishes to stress that the combination of retrospective budgeting and monthly reporting is not necessarily unresponsive to need, particularly in light of the protective modifications and exceptions to the system that the Secretary is empowered to institute by way of regulation. Recent data collected by HEW from the monthly reporting project it is supporting in Denver, Colorado, indicate that the combined system, when compared to the old prospective system, yielded five times as many changes in client circumstances resulting in an increase in welfare benefits, but only twice as many changes leading to a decrease. Thus, the combination, utilized by States on a fully elective basis, may well reduce the lags in response time to changed households circumstances, while benefiting recipients and reducing errors.

Nonetheless, a periodic reporting system of the type envisioned in this bill, with all of its attendant regulatory limitations, is obviously difficult to implement. States need sufficient lead time adequately to

prepare for this change and work with their caseloads to effectuate it. States should allow a transition period in which households could proceed to learn the system before they are terminated for failure to file timely and complete reports.

The bill would make changes in other portions of the 1977 Act in order to accommodate periodic reporting. Since periodic reporting yields current information for the purpose of determining continued eligibility and levels of benefits, it effectively satisfies the same purpose previously furthered by brief certification periods. Therefore, the certification periods of households required in either retrospective or hybrid prospective accounting States to submit periodic reports need not be as short as before and, indeed, ought to be lengthened to at least six but no longer than twelve months (unless a longer period was determined to be essential for coordination with the certification periods for supplemental security income recipients) to eliminate costly and unnecessary recertifications while, at the same time, assuming that these households are subject once or twice a year to a complete reexamination of their circumstances.

In addition, the method of handling income of less than $30 a quarter, which is now excluded under section 5(d)(2) of the act if it is received too infrequently or irregularly to be reasonably anticipated, ought to be changed as the Secretary so determines to convert the dollar exclusionary figure to a monthly rather than a quarterly amount in order to make it easier for households submitting periodic reports to determine when these small amounts had to be reported. The Secretary, could, for example, make the limit $10 a month, but he could not so adjust the monthly figure as to make the amount excludible in any quarter exceed $30.

The last provision that might be modified, if the Secretary deems it advisable, in order to implement retrospective accounting and monthly reporting is the prescription of timeliness standards for handling recertifications contained in section 11(e)(4) of the act. These timeliness standards might not prove applicable under the new system and could be changed so long as the standards as modified would still provide households a reasonable opportunity to be notified of the expiration of their (in many instances, lengthened) certification period and to reapply and would still ensure that eligible households that did reapply experience no interruption in the receipt of their benefits. For example, in appropriate months, the State could send an application rather than a monthly report and have the household return in person with the application.

5. VERIFICATION

In the Food Stamp Act of 1977, the Congress sought to simplify and shorten the food stamp certification process. It mandated a uniform national application form in section 11(e)(2). It insisted upon prompt eligibility determinations based upon a uniform system of verification (that is the use of third-party information or of documentation to ascertain the accuracy of statements made on a food stamp application) subject to the control of the Secretary in section 11(e)(3). The object was to balance concern for the food needs of eligible applicants, who should be assured in advance that their ap-

Anyone familiar with the American institution of collective bargaining knows that strikes occur for many reasons. For example:

Management may decide it can defeat or cripple a union and, thus, pushes the labor group into one corner after another, until a strike occurs.

Management and or the union may not want a strike, but may so miscalculate in bargaining actions that a strike becomes inevitable.

A union may think it can force demands on management which it cannot achieve without a strike.

Management and workers may have accumulated so much bitterness over the years that the bargainers on both sides realize that clearing the air with a strike, allowing an emotional blowoff, is the best way to improve the relationship and start off on a new footing.

A highly vocal minority in either management or the union may push its group into a strike for some internal reason.

Also, unions consider major management contract proposals and strike authorizations in secret ballot votes of the members involved. If a strike is called, a majority voted for it and a minority against it. It would be particularly unfair to deny food stamps to involuntary strikers or strikers in a management-caused strike.

Finally, had the pure bar carried, there would be the anomaly that under the food stamp laws, if a man or other head of the household were convicted of a felony, whether it be murder, robbery, rape, or treason, and incarcerated in a penitentiary for that offense, his family would still be eligible for food stamps. But, under the amendment, if a man were out on strike, his family would not be eligible.

It is not possible to justify such discrimination against hard working, responsible citizens.

D. The Certification Process

1. SIMPLE FORM

In section 11(i) of the Food Stamp Act of 1977, the Congress, seeking to streamline and render quick and efficient the process by which elderly, blind, and disabled recipients of supplemental security income (SSI) apply for food stamps as well, ordered the Secretary and the Secretary of Health, Education, and Welfare to develop a system allowing households consisting solely of SSI recipients to seek certification at the same social security office at which they qualify for SSI by filing a simplified affidavit which would provide the basis for determining their eligibility together with information contained in the files of the Social Security Administration (SSA). The hope was that this system would lessen the significant burden of forcing SSI recipients to deal with two different offices in order to qualify for both programs.

Unfortunately, the prospect that such a shortened and simplified affidavit could be used nationwide by SSA for joint application purposes could not be worked out by the Department and SSA because much of the information needed to determine food stamp eligibility

is not needed to determine SSI eligibility, since there are considerable differences in income and asset definitions and income and asset exclusion in the two programs. Thus, the affidavit could not be developed as a short form attached to the SSI application/redetermination form. It was found to be impractical.

Accordingly, the Department proposed to allow State agencies to have the option to use the national food stamp application form or a comparable State form no more lengthy or complex. There will be no greater burden upon clients under this approach as long as the SSI caseworker fills out that application form during the SSI interview and then forwards the form to the appropriate food stamp office. This Committee wants to ratify the Department's approach and, therefore, would change the requirement of a "simplified affidavit" to a "simple application", which would be no more complex than the Department's national food stamp application form.

2. DEVIATION FROM THE UNIFORM APPLICATION FORM

The Committee believes that in issuing and enforcing regulations under this Act, the Secretary should encourage State agencies to implement systems that will provide for the combined administration of several public assistance programs, a policy already expressed in section 11(i) and (j) of the Act. Establishment of systems to handle several welfare programs will improve the administration of those programs in a number of ways, including permitting recipients to apply for benefits in several programs at once, saving administrative costs, and reducing error rates in the distribution of benefits. The Committee has already given the Secretary explicit authority to permit deviation from the uniform application form in order for a State agency to be able to use a dual public assistance-food stamp application form. See section 11(e)(2). The Committee expects that the Secretary will use this authority liberally to encourage such States as California, Georgia, New York, Illinois, Louisiana, North Carolina, Virginia, Washington, and Wisconsin to implement such systems, provided that the systems comply with the other provisions of the Act with respect to such matters as expedited service for the immediately needy and destitute under section 11(e)(9) and prompt application processing triggered by the filing of a form that contains the applicant household's name, address, and appropriate signature, rather than only by the filing of a completed form, which should be allowed to be filed on the same day that contact is made in person with a food stamp office. See section 11(e)(2) of the Act and 7 C.F.R. § 273.2.

5. REPORTING ILLEGAL ALIENS

In the Food Stamp Certification Handbook that was in effect under the 1964 Food Stamp Act certification workers were instructed in section 2208.9 that:

"If, in the application process, it becomes known to the State agency that an alien has entered or remained in the United States illegally and INS (Immigration and Naturalization Service) has not declined deportation action, such alien shall be promptly brought to the atten-

96TH CONGRESS
3d Session
HOUSE OF REPRESENTATIVES
REPORT
No. 96-957

FOOD STAMP ACT AMENDMENTS OF 1980

MAY 14, 1980.—Ordered to be printed

Mr. FOLEY, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany S. 1309]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 1309) to increase the fiscal year 1979 authorization for appropriations for the food stamp program, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

That this Act may be cited as the "Food Stamp Act Amendments of 1980".

TITLE I—REDUCTION IN FOOD STAMP ERROR AND FRAUD AND REVISION OF DEDUCTIONS

MEALS IN SHELTERS FOR BATTERED WOMEN AND CHILDREN

SEC. 101. (a) Section 3 of the Food Stamp Act of 1977, is amended by—

(1) striking out in clause (1) of subsection (g) "and (7)" and inserting in lieu thereof "(7), and (8)";

(2) striking out in subsection (g) "and (7)" and inserting in lieu thereof "(7)";

(3) inserting immediately before the period at the end of subsection (g) the following: ", and (8) in the case of women and

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The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(B) The *House* amendment also, effective October 1, 1981, expands the existing excess medical expense deduction for the elderly, blind, and disabled by removing the threshold above which expenses are deductible (currently $35 a month).

The *Senate* bill provides that the $35 a month threshold for the excess medical expense deduction will be indexed semiannually beginning July 1, 1979, according to Consumer Price Index changes for items other than food.

The *Conference* substitute adopts the *House* provision, but sets the threshold above which such expenses are deductible at $25 a month. The conferees intend that the deduction will be implemented together with all other changes in deductions on January 1 of the fiscal year in which it takes effect.

(6) Medical deductions for the blind and disabled in certain areas

The *House* amendment, effective October 1, 1981, extends the availability of the excess medical expense deduction to blind or disabled persons (and their spouses) in Puerto Rico, Guam, and the Virgin Islands, when they receive cash welfare payments through programs equivalent to the Supplemental Security Income (SSI) program. [Note: Existing law allows the elderly, and blind or disabled persons receiving Social Security payments, to claim the excess medical expense deduction in these areas.]

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision. The conferees intend that the deduction will be implemented together with all other changes in deductions on January 1 of the fiscal year in which it takes effect.

(7) Retrospective accounting

(A) The *House* amendment permits States the option to determine program eligibility and benefits by using income received in a previous month, following standards prescribed by the Secretary. In the month of application and subsequent months (as determined by the Secretary), this retrospective accounting system would not apply, except when a household reapplies within 30 days after the end of a prior certification period. Modifications or exceptions would be required in the retrospective accounting system for (i) all households experiencing losses of income of $50 per month or more, or other sudden and significant losses of income; (ii) all households with new members; (iii) all households in immediate need requiring expedited services; (iv) migrant farmworker households; and (v) other classes of households for whom the Secretary determines the system would be impracticable to administer or for whom retrospective accounting would cause serious hardship. [Note: The *House* report states that the retrospective accounting option may be exercised in some or all project areas and for certain classes of households (defined by the Secretary).]

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provisions.

(B) The *House* amendment requires the Secretary to consult with the Secretary of Health, Education, and Welfare in promulgating regulations governing income calculations for the food stamp pro-

gram so that, whenever feasible and consistent with the applicable Acts, households receiving income from the aid to families with dependent children (AFDC) program will have their income calculated on a consolidated and comparable basis.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(8) Vehicle use by handicapped household members

The *House* amendment exempts from valuation as a household resource, for purpose of the assets requirements, any vehicle used to transport a disabled household member, regardless of the purpose of such transportation.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision with a limitation that the disabled person be physically disabled so that such person requires a vehicle in order to be transported.

(9) State option on administrative fraud hearings

The *House* amendment permits each State to decide to proceed against alleged fraud in the program either by way of administrative fraud hearings or by way of reference to appropriate legal authorities for civil or criminal action, or both. [Note: The *House* report states that the *House* amendment does not require a State to create an administrative fraud hearing system unless the Secretary finds that it is not promptly, actively, and seriously handling fraud cases civilly or criminally.]

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(10) Periodic reporting

(A) the *House* amendment provides that States electing to use a retrospective accounting system shall require certain categories of households (determined by the Secretary) to file periodic (normally monthly) reports of household circumstances following standards prescribed by the Secretary. Other States could require periodic reporting by the same categories of households, with the Secretary's approval. Households that are not required to file periodic reports on a monthly basis would be required to report, on a form designed and approved by the Secretary, changes in income or household circumstances that the Secretary deems necessary to assure accurate eligibility and benefit determinations.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(B) The *House* amendment provides that households required to file a periodic report, if eligible to participate and if having filed a timely and complete report, shall receive their allotment, based on the reported information for a given month, within 30 days of the end of that month, unless the Secretary determines that a longer period of time is necessary.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(C) The *House* amendment requires that there be special procedures available for households required to file a periodic report if all adult household members are mentally or physically handi-

capped or lacking in reading or writing skills rendering them unable to fill out the required forms.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(D) The *House* amendment provides that households required to file a periodic report shall have a reasonable period of time after the close of the month in which to file their reports, be afforded prompt notice of failure to timely or completely file any report, be given an opportunity to cure that failure, and a reasonable opportunity to exercise their appeal rights under the Act.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(E) The *House* amendment provides that any periodic or other reports filed by households shall be considered complete if, under standards prescribed by the Secretary, they contain sufficient information to enable determination of eligibility and benefit levels.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(F) The *House* amendment requires the Secretary to consult with the Secretary of Health, Education, and Welfare in implementing the periodic reporting requirements and, whenever feasible, households that receive income under the aid for families with dependent children (AFDC) program and that are required to file comparable reports under that program would be provided the opportunity to file reports at the same time for the purposes of both programs.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(G) The *House* amendment provides that households required to submit periodic reports are to be given certification (of eligibility) periods of at least 6 months, but no longer than 12 months.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(H) The *House* amendment makes changes in other provisions of the Food Stamp Act to conform them to any retrospective accounting-periodic reporting system by (ii) allowing the Secretary to modify the "irregular income" exclusion; and (ii) allowing the Secretary to modify timeliness standards for notices of expiration and applying for recertification.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(11) Expansion of work registration requirement

The *House* amendment reduces the age of a dependent child who exempts his or her parent or caretaker from the work registration requirement from under age 12 to under age 6.

The *Senate* bill contains no comparable provision.

The *Conference* substitute deletes the *House* provision.

(12) Participation by striker

The *House* amendment specifically provides that no household that contains a person on strike in a labor-management dispute shall be eligible to participate in the food stamp program, unless (A) the household was eligible to participate prior to the strike, or (B) the household otherwise meets the income qualifications, assets

of operations, or the Secretary's standards for the efficient and effective administration of the Act.

The *House* amendment requires the Secretary, if he receives information of such failure to comply or determines that such failure exists after an investigation voluntarily initiated by him or mandatorily initiated by him upon receipt of sufficient information evidencing a pattern of lack of compliance, to proceed to inform a State of such failure and allow the State reasonable time to correct such failure. [Note: The *House* report states that the *House* amendment allows the State to administratively show good cause for failure to comply.] The *House* amendment further permits the Secretary, if the State fails to undertake timely and appropriate corrective action, to refer the matter to the Attorney General for injunctive relief and, whether or not such referral is made, to proceed to withhold such administrative cost-sharing funds from the State as he determines to be appropriate.

The *Senate* bill contains no comparable provisions.

The *Conference* substitute adopts the *House* provisions with amendments to (A) require that the Secretary find that a State has failed without good cause to comply with the Act, regulations, its own plan of operations, or the Secretary's standards for the efficient and effective administration of the Act before proceeding to inform the State of such failure and (B) entitle any State from which the Secretary determines to withhold funds authorized under sections 16 (a) and (c) of the Act to subject the claim to administrative and judicial review in accordance with section 14 of the Act.

(20) Social security office application

The *House* amendment allows households in which all members are supplemental security income recipients to apply to participate in the food stamp program by filling out a simple application form, either the national food stamp application form or a simple State application form of comparable length and complexity, rather than the simplified affidavit required by existing law.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(21) Special financial audit review of high participation States

The House amendment requires the Inspector General to immediately schedule a financial audit review of a sample of project areas in any State in which, in any quarter of a fiscal year, the average food stamp participation exceeds 60 percent of the total State population, and report his findings and recommendations to the Congress within two fiscal-year quarters thereafter.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision with an amendment to limit the mandatory auditing of any one State by the Department's Office of Inspector General to one audit with any remaining audits to be at the option of the Office of Inspector General.

fy the statutory standards. The *House* amendment permits imposition of reductions or claims to be avoided by showing of good cause for failure to meet the standards and would subject a claim for a payment by the Secretary under this section to administrative and judicial review.

The *House* amendment requires the Secretary to conduct a study to determine whether it would be feasible to include invalid decisions denying eligibility in the calculation of each State's payment error rate and the national standards.

The *Senate* bill conatains no comparable provisions.

The *Conference* substitute adopts the *House* provisions with the understanding that the showing of good cause for failure to meet the standards that a State may make shall include sudden and unanticipated workload increases or confusion attributable to significant changes in Federal regulations.

(25) Disclosure provisions

The *House* amendment required the disclosure of certain income tax information in the files of the Social Security Administration and certain wage and unemployment insurance (UI) information in the records of State UI agencies to the Department and State food stamp agencies only for the purpose of, and to the extent necessary for, determining a person's eligibility for food stamps. The *House* amendment requires that tax return information be disclosed in accordance with the procedures, conditions and safeguards specified in section 6103 of the Internal Revenue Code. The *House* amendment, effective January 1, 1983, further provides that as a condition of receipt of its Federal UI administrative grant, each State UI agency would have to make available, under procedures and safeguards to be established by the Secretary of Labor, information in its records pertaining to an individual's wages, home address, UI eligibility, and offers of employment.

The *Senate* bill contains no comparable provisions.

The *Conference* substitute adopts the *House* provisions.

(26) Payment of certain legal fees

The *House* amendment permits the use of program funds to pay for the employment of counsel, court costs, bail, and other incidental defense expenses on behalf of the Department's officers and employees involved as parties in judicial or administrative proceedings arising directly out of the performance of their duties under the food stamp program.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(27) Continuation of cash-out pilot projects

The *House* amendment requires continuation of pilot projects involving the payment of the value of allotments in cash to eligible households all of whose members are either 65 years of age or older or who participate in the supplemental security income program for an additional 6 months beyond their scheduled termination date (March 31, 1981) until October 1, 1981, should legislation be enacted before March 31, 1981, that universally cashes out food stamps for certain SSI beneficiaries effective October 1, 1981.

The *Senate* bill contains no comparable provision.

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96TH CONGRESS, 1st Session | SENATE | REPORT No. 96-236

INCREASE IN FISCAL YEAR 1979 AUTHORIZATION FOR APPROPRIATIONS FOR THE FOOD STAMP PROGRAM

JULY 6 (legislative day, JUNE 21), 1979.—Ordered to be printed
Filed, under authority of the order of the Senate of June 27 (legislative day, June 21), 1979

Mr. MCGOVERN, from the Committee on Agriculture, Nutrition, and Forestry, submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany S. 1309]

The Committee on Agriculture, Nutrition, and Forestry, to which was referred the bill (S. 1309) to increase the fiscal year 1979 authorization for appropriations for the food stamp program, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill as amended do pass.

SHORT EXPLANATION

I

S. 1309, as amended by the Committee, would—

(1) increase the fiscal year 1979 authorization for appropriations for the food stamp program by $620 million (from $6,158,900,000 to $6,778,900,000);

(2) eliminate the authority allowing for carryover of unexpended funds from one fiscal year to the next;

(3) allow the elderly and the disabled to deduct (A) medical expenses over $35 per month and (B) shelter expenses over 50 percent of income, to the extent incurred; and

(4) permit the Secretary to make reductions in the value of food stamp allotments on other than a pro rata basis if such action becomes necessary due to any insufficiency of appropriated funds.

[redacted]

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No material re social security in this report.

96TH CONGRESS
2d Session

SENATE

REPORT
No. 96-704

FOOD STAMP ACT AMENDMENTS OF 1980

MAY 14 (legislative day JANUARY 3), 1980.—Ordered to be printed

Mr. TALMADGE, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany S. 1309]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 1309) to increase the fiscal year 1979 authorization for appropriations for the food stamp program, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

That this Act may be cited as the "Food Stamp Act Amendments of 1980".

TITLE I—REDUCTION IN FOOD STAMP ERROR AND FRAUD AND REVISION OF DEDUCTIONS

MEALS IN SHELTERS FOR BATTERED WOMEN AND CHILDREN

SEC. 101. (a) Section 3 of the Food Stamp Act of 1977, is amended by—

(1) striking out in clause (1) of subsection (g) "and (7)" and inserting in lieu thereof "(7), and (8)";

(2) striking out in subsection (g) "and (7)" and inserting in lieu thereof "(7)";

(3) inserting immediately before the period at the end of subsection (g) the following: ", and (8) in the case of women and

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(B) The *House* amendment also, effective October 1, 1981, expands the existing excess medical expense deduction for the elderly, blind, and disabled by removing the threshold above which expenses are deductible (currently $35 a month).

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The *Conference* substitute adopts the *House* provision, but sets the threshold above which such expenses are deductible at $25 a month. The conferees intend that the deduction will be implemented together with all other changes in deductions on January 1 of the fiscal year in which it takes effect.

(6) Medical deductions for the blind and disabled in certain areas

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The *Senate* bill contains no comparable provision.

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(7) Retrospective accounting

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The *Senate* bill contains no comparable provision.

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(B) The *House* amendment requires the Secretary to consult with the Secretary of Health, Education, and Welfare in promulgating regulations governing income calculations for the food stamp pro-

gram so that, whenever feasible and consistent with the applicable Acts, households receiving income from the aid to families with dependent children (AFDC) program will have their income calculated on a consolidated and comparable basis.

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The *Conference* substitute adopts the *House* provision with a limitation that the disabled person be physically disabled so that such person requires a vehicle in order to be transported.

(9) State option on administrative fraud hearings

The *House* amendment permits each State to decide to proceed against alleged fraud in the program either by way of administrative fraud hearings or by way of reference to appropriate legal authorities for civil or criminal action, or both. [Note: The *House* report states that the *House* amendment does not require a State to create an administrative fraud hearing system unless the Secretary finds that it is not promptly, actively, and seriously handling fraud cases civilly or criminally.]

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(10) Periodic reporting

(A) the *House* amendment provides that States electing to use a retrospective accounting system shall require certain categories of households (determined by the Secretary) to file periodic (normally monthly) reports of household circumstances following standards prescribed by the Secretary. Other States could require periodic reporting by the same categories of households, with the Secretary's approval. Households that are not required to file periodic reports on a monthly basis would be required to report, on a form designed and approved by the Secretary, changes in income or household circumstances that the Secretary deems necessary to assure accurate eligibility and benefit determinations.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(B) The *House* amendment provides that households required to file a periodic report, if eligible to participate and if having filed a timely and complete report, shall receive their allotment, based on the reported information for a given month, within 30 days of the end of that month, unless the Secretary determines that a longer period of time is necessary.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(C) The *House* amendment requires that there be special procedures available for households required to file a periodic report if all adult household members are mentally or physically handi-

capped or lacking in reading or writing skills rendering them unable to fill out the required forms.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(D) The *House* amendment provides that households required to file a periodic report shall have a reasonable period of time after the close of the month in which to file their reports, be afforded prompt notice of failure to timely or completely file any report, be given an opportunity to cure that failure, and a reasonable opportunity to exercise their appeal rights under the Act.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(E) The *House* amendment provides that any periodic or other reports filed by households shall be considered complete if, under standards prescribed by the Secretary, they contain sufficient information to enable determination of eligibility and benefit levels.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(F) The *House* amendment requires the Secretary to consult with the Secretary of Health, Education, and Welfare in implementing the periodic reporting requirements and, whenever feasible, households that receive income under the aid for families with dependent children (AFDC) program and that are required to file comparable reports under that program would be provided the opportunity to file reports at the same time for the purposes of both programs.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(G) The *House* amendment provides that households required to submit periodic reports are to be given certification (of eligibility) periods of at least 6 months, but no longer than 12 months.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(H) The *House* amendment makes changes in other provisions of the Food Stamp Act to conform them to any retrospective accounting-periodic reporting system by (ii) allowing the Secretary to modify the "irregular income" exclusion; and (ii) allowing the Secretary to modify timeliness standards for notices of expiration and applying for recertification

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(11) Expansion of work registration requirement

The *House* amendment reduces the age of a dependent child who exempts his or her parent or caretaker from the work registration requirement from under age 12 to under age 6.

The *Senate* bill contains no comparable provision.

The *Conference* substitute deletes the *House* provision.

(12) Participation by striker

The *House* amendment specifically provides that no household that contains a person on strike in a labor-management dispute shall be eligible to participate in the food stamp program, unless (A) the household was eligible to participate prior to the strike, or (B) the household otherwise meets the income qualifications, assets

of operations, or the Secretary's standards for the efficient and effective administration of the Act.

The *House* amendment requires the Secretary, if he receives information of such failure to comply or determines that such failure exists after an investigation voluntarily initiated by him or mandatorily initiated by him upon receipt of sufficient information evidencing a pattern of lack of compliance, to proceed to inform a State of such failure and allow the State reasonable time to correct such failure. [Note: The *House* report states that the *House* amendment allows the State to administratively show good cause for failure to comply.] The *House* amendment further permits the Secretary, if the State fails to undertake timely and appropriate corrective action, to refer the matter to the Attorney General for injunctive relief and, whether or not such referral is made, to proceed to withhold such administrative cost-sharing funds from the State as he determines to be appropriate.

The *Senate* bill contains no comparable provisions.

The *Conference* substitute adopts the *House* provisions with amendments to (A) require that the Secretary find that a State has failed without good cause to comply with the Act, regulations, its own plan of operations, or the Secretary's standards for the efficient and effective administration of the Act before proceeding to inform the State of such failure and (B) entitle any State from which the Secretary determines to withhold funds authorized under sections 16 (a) and (c) of the Act to subject the claim to administrative and judicial review in accordance with section 14 of the Act.

(20) Social security office application

The *House* amendment allows households in which all members are supplemental security income recipients to apply to participate in the food stamp program by filling out a simple application form, either the national food stamp application form or a simple State application form of comparable length and complexity, rather than the simplified affidavit required by existing law.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision.

(21) Special financial audit review of high participation States

The House amendment requires the Inspector General to immediately schedule a financial audit review of a sample of project areas in any State in which, in any quarter of a fiscal year, the average food stamp participation exceeds 60 percent of the total State population, and report his findings and recommendations to the Congress within two fiscal-year quarters thereafter.

The *Senate* bill contains no comparable provision.

The *Conference* substitute adopts the *House* provision with an amendment to limit the mandatory auditing of any one State by the Department's Office of Inspector General to one audit with any remaining audits to be at the option of the Office of Inspector General.

after the date of enactment of this Act for fiscal year 1980, with the Secretary's authority under the amendment to lapse if funds for June 1980 are appropriated before June 1.

The *Senate* bill contains no comparable provisions.

The *Conference* substitute deletes the *House* provision.

(38) Authorization for appropriations ceiling for 1980 and 1981

The *Senate* bill removes the specific dollar authorization for appropriations ceilings for fiscal years 1980 and 1981.

The *House* amendment replaces the existing fiscal year 1980 ceiling of $6,188,600,000 with a new ceiling of $9,191,000,000 and the existing fiscal year 1981 cap of $6,235,900,000 with a new cap of $9,739,276,000.

The *Conference* substitute adopts the *House* provision with an amendment to increase the fiscal year 1980 ceiling to $9,491,000,000. The conferees intend that the Secretary not act under section 18(b) of the Food Stamp Act to reduce allotments in fiscal year 1981 until such time as the House and the Senate have had an opportunity to consider legislation reauthorizing the food stamp program.

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GEORGE MCGOVERN,
WALTER D. HUDDLESTON,
PATRICK J. LEAHY,
JOHN MELCHER,
BOB DOLE,
Managers on the Part of the Senate.

THOMAS S. FOLEY,
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LEON E. PANETTA,
RICHARD NOLAN,
DAN GLICKMAN,
DANIEL K. AKAKA,
TOM HARKIN,
BILL WAMPLER,
PAUL FINDLEY,
MARGARET M. HECKLER,
JAMES M. JEFFORDS,
Managers on the Part of the House.

○

Finder's Aid

P.L. 96-265 (94 Stat. 441) Approved June 9, 1980
"Social Security Disability Amendments of 1980"

Subject	SS Act Section	P.L. Section	94 Stat.	H.Rep. 96-100	S.Rep 96-408	H.C.Rep. 96-944
Payment of Certain Travel Expenses	201(j)	310(a)	459	4, 29	60	60
Allocation of Costs for Demonstration Projects	201(k)	505(a)(5)	474	7, 24	81-83	72-73
Child's Insurance Benefits--Reentitlement to Disability Benefits	202(d)(1)(G)	303(b)(1)(B)	451	7-8 24-25	51	53-54
Child's Insurance Benefits--Disability Insurance Benefits--(I) Medical Recovery (II) Able Engage Substantial Gainful Activity	202(d)(1)(G)(i) (new (G)(I) and (G)(II))	303(b)(1)(B)(ii)	451	7-8 24-25	51	53-54
Child's Insurance Benefits--Disability Insurance Benefits Technical Amendment	202(d)(1)(G)(i) (Redesignated as (G)(III))	303(b)(1)(B)(i)	451	24-25	51	53-54
Child's Insurance Benefits--Disability Insurance Benefits Technical Amendment	202(d)(1)(G)(ii) (Redesignated as (G)(IV))	303(b)(1)(B)(i)	451	24-25	51	53-54
Widow's Benefits--Trial Work--Extension of Disability Insurance Benefits	202(e)(1)	303(b)(1)(c)	452	7-8 24-25	51	53-54
Widower's Benefits--Trial Work--Extension of Disability Insurance Benefits	202(f)(1)	303(b)(1)(D)	452	7-8 24-25	51	53-54
Limit on Prospective Effect of Application	202(j)(2)	306(a)	457	26-27	57	--
Limit on Family Disability Insurance Benefits	203(a)(1)	101(a)(1)	442	2, 4-6	35-41	45
Limit on Family Disability Insurance Benefits Technical Amendment	203(a)(2)(D)	101(b)(1)	442	2	35-41	45
Limit to 85% AIME or 150% PIA	203(a)(6) (new)	101(a)(3)	442	2, 4-6	35-41	45
Technical Amendment	203(a)(6) (Redesignated (a)(7))	101(a)(2	442	2	35-41	45
Technical Amendment	203(a)(7) (Redesignated (a)(8))	101(a)(2)	442	2	35-41	45
Technical Amendment	203(a)(8)	101(b)(2)	442	2	35-41	45
Technical Amendment	203(a)(8) (Redesignated (a)(9))	101(a)(2)	442	2	35-41	45

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Subject	SS Act Section	P.L. Section	94 Stat.	H.Rep. 96-100	S.Rep. 96-408	H.C.Rep. 96-944
Adjust Title II Retroactive Benefits for Supplemental Security Income	204(e)	501(b)	470	--	78-79	69
Information to Support Decision Re Disability	205(b)	305(a)	457	12, 26, 37	56-57	58
Limitation on Court Remands	205(g)	307	458	13, 27, 31	58-59	58-59
Reduction Drop-out Years for Young Disabled	215(b)(2)(A)	102(a)	443	2-3 6-7 32-35	41-43	46-47
Technical Amendment	215(i)(2)(A)(ii)(III)	101(b)(3)	442	--	--	--
Limit on Total Disability Insurance Family Benefits	215(i)(2)(D)	101(b)(4)	442	2, 4-6	35-41	45
Disability Ends (Trial Work)	216(i)(2)(D)	303(b)(2)(B)	453	7-8	51	53-54
Limit on Prospective Effect of Application	216(i)(2)(G)	306(b)(1)	457	26-27	57	--
Limit on Prospective Effect of Application	216(i)(2)(G)	306(b)(2)	457	26-27	57	--
Limit on Prospective Effect of Application	216(i)(2)(G)	306(b)(3)	458	26-27	57	--
State and Local Payment Schedule for FICA Deposits	218(e)(1)(A)	503(a)	470	--	79-80	70
Disability Determination-- Administration by State Agencies	221(a)	304(a)	453	8-10	52-56	54-55
Disability Determination-- Administration by State Agencies	221(b)	304(b)	454	8-10	52-56	54-55
Federal Review of State Agency Decisions--Decisions Reversals by Secretary	221(c)	304(c)	455	8-10	52-56	56-57
Technical Amendment	221(d)	304(d)	456	--	--	--
Disability Determination-- Administration by State Agencies	221(e)	304(e)(1)	456	8-10	52-56	54-55
Disability Determination-- Administration by State Agencies	221(e)	304(e)(2)	456	8-10	52-56	54-55
Disability Determination-- Administration by State Agencies	221(e)	304(e)(3)	456	8-10	52-56	54-55
Disability Decision-- Administration by State Agencies	221(g)	304(f)(1)	456	8-10	52-56	54-55

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Subject	SS Act Section	P.L. Section	94 Stat.	H.Rep. 96-100	S.Rep. 96-408	H.C.Rep. 96-944
Disability Decision--Administration by State Agencies	221(g)	304(f)(2)	456	8-10	52-56	54-55
Periodic Review of Disability Determinations	221(i)	311(a)	460	25-26	60-16	60-61
Trial Work Definition Amendment	222(c)(1)	303(a)(1)	451	7-8	51	53-54
Trial Work Re-entitlement to Disability Insurance Benefits	222(c)(3)	303(a)(2)	451	7-8	51	53-54
Trial Work Termination Month	223(a)(1)	303(b)(1)(A)	451	7-8	51	53-54
Reduction Dropout Years	223(a)(2)	102(b)	433	6-7	41-43	46-47
Limit on Prospective Effect of Application	223(b)	306(c)(1)	458	26-27	57	--
Limit on Prospective Effect of Application	223(b)	306(c)(2)	458	26-27	57	--
Limit on Prospective Effect of Application	223(b)	306(c)(3)	458	26-27	57	--
Extra Work Expense (SGA) in Severe Disability	223(d)(4)	302(a)(1)	450	7	50-51	53
Payment For Existing Medical Evidence	223(d)(5)	309(a)	459	13	59-60	59-60
SGA/Trial Work	223(e)	303(b)(2)(A)	453	7-8	51	53-54
Continued Pay of Benefits to Persons Under Vocational Rehabilitation Plans	225(a) (Redesignated formerly §225)	301(a)(1)	449	3, 11-12	48-50	52
Technical Amendment	225(a) (as Redesignated)	301(a)(2)	450	--	--	--
Continued Pay of Benefits to Persons Under Vocational Rehabilitation Plans	225(b) (new)	301(a)(1)	449	28	48-50	52
Medicare Waiting Period	226(b)(2)(A)	103(a)(1)(A)	444	7-8	43	47
Medicare Waiting Period	226(b)(2)(B)	103(a)(1)(A)	444	7-8	43	47
Medicare Waiting Period	226(b)(end)	103(a)(1)(B)	444	7-8	43	47
Continuation of Medicare Eligibility	226(b)(end)	104(a)(1)	444	7-8	43-44	47
Continuation of Medicare Eligibility	226(b)(end)	104(a)(2)	444	7-8	43-44	47
Elimination Second Medicare Waiting Period	226(f) (new)	103(b)	444	7-8	43	47
Elimination Second Medicare Waiting Period	226(f) (Redesignated as (g))	103(b)	444	7-8	43	47

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Subject	SS Act Section	P.L. Section	94 Stat.	H.Rep. 96-100	S.Rep. 96-408	H.C.Rep. 96-944
Access to Wage Information For Child Support Program	303(d)(sic)	408(b)(1)	468	--	71	66-68
Access to Wage Information For Child Support Program	304(a)(2)	408(b)(2)	469	--	71	66-68
Disclosure of Information For AFDC and Social Services	402(a)(9)(B)	403(a)(1)	462	--	65-66	63-64
Disclosure of Information for AFDC and Social Services	402(a)(9)(C)	403(a)(2)	462	--	65-66	63-64
AFDC Work Requirement	402(a)(19)(A)	401(a)(1)	460	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(A)(v)	401(a)(2)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(A)(vi)	401(a)(3)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(A)(vi)	401(a)(4)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(A)(vii)	401(a)(5)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(B)	401(b)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(D)	401(c)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(F)	401(d)(1)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(F)(end)	401(d)(2)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(F)(end)	401(f)(1)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(G)	401(e)(1)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(G)(ii)	401(e)(2)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(G)(ii)	401(e)(3)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(G)(ii)	401(e)(4)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(G)(end)	401(f)(2)	461	--	61-63	62-63
AFDC Work Requirement	402(a)(19)(H)	401(f)(3)	461	--	61-63	62-63
AFDC Management Information System	402(a)(28)	406(b)(1)(A)	465	--	69-70	65
AFDC Management Information System	402(a)(29)	406(b)(1)(B)	465	--	69-70	65
AFDC Management Information System	402(a)(30)	406(b)(1)(C)	465	--	69-70	65
AFDC Management Information System	402(d)	406(b)(2)	466	--	69-70	65
AFDC Management Information System	403(a)(3)(A)	406(a)(1)	465	--	69-70	65

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Subject	SS Act Section	P.L. Section	94 Stat.	H.Rep. 96-100	S.Rep. 96-408	H.C.Rep. 96-944
AFDC Management Information System	403(a)(3)(B) (new)	406(a)(3)	465	--	69-70	65
AFDC Management Information System	403(a)(3)(B) (Redesignated (C))	406(a)(2)	465	--	69-70	65
Child Support Reporting and Matching Procedure	403(b)(2)(A)	407(c)(1)	467	--	70-71	66
Child Support Reporting and Matching Procedure	403(b)(2)(B)	407(c)(2)	467	--	70-71	66
AFDC Work Requirement	403(c)	401(g)	462	--	61-63	62-63
AFDC Work Requirement	403(d)(1)	401(h)	462	--	61-63	62-63
AFDC Management Information System	413	406(c)	467	--	69-70	65
Use of I.R.S. to Collect Child Support For Non-AFDC Families	452(b)	402(a)	462	--	65	63
Child Support Management Information System	452(d)	405(c)	464	--	68-69	65
Child Support Management Information System (Technical Assistance to States)	452(e)	405(d)	465	--	68-69	65
Child Support Management Information System	454(14)	405(b)(1)	463	--	68-69	65
Child Support Management Information System	454(15)	405(b)(2)	463	--	68-69	65
Child Support Management Information System	454(16)	405(b)(3)	463	--	68-69	65
Child Support Management Information System	455(a)(1)	405(a)(1)	463	--	68-69	65
Child Support Management Information System	455(a)(2)	405(a)(2)	463	--	68-69	65
Child Support Management Information System	455(a)(3)	405(a)(3)	463	--	68-69	65
Child Support Report and Matching Procedures	455(b)(2)	407(a)	467	--	70-71	66
Federal Matching For Child Support Activity by Court Personnel	455(c)	404(a)	463	--	66-68	64
Child Support Report and Matching Procedures	455(d)	407(b)	467	--	70-71	66
Work Incentive and Other Experiments and Demonstration Projects (DI and SSI)	1110	505(b)(4)	474	3, 4-8	82-83	72-73
Work Incentive and Other Experiments and Demonstration Projects (DI and SSI)	1110	505(b)(5)	474	3, 4-8	82-83	72-73

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Subject	SS Act Section	P.L. Section	94 Stat.	H.Rep. 96-100	S.Rep. 96-408	E.C.Rep. 96-944
Work Incentive and Other Experiments and Demonstration Projects (DI and SSI)	1110(a)(1)	505(b)(1)	474	3, 4-8	82-83	72-73
Work Incentive and Other Experiments and Demonstration Projects (DI and SSI)	1110(a)(1)	505(b)(2)	474	3, 4-8	82-83	72-73
Work Incentive and Other Experiments and Demonstration Projects (DI and SSI)	1110(a)(2)	505(b)(2)	474	3, 4-8	82-83	72-73
Work Incentive and Other Experiments and Demonstration Projects (DI and SSI)	1110(b) (Redesignated 1110(a)(2))	505(b)(3)	474	3, 4-8	82-83	72-73
Work Incentive and Other Experiments and Demonstrations Projects (DI and SSI)	1110(c)	505(b)(3)	474	3, 4-8	82-83	72-73
Work Incentive and Other Experiments and Demonstrations Projects (DI and SSI)	1110(b) (new)	505(b)(6)	474	3, 4-8	82-83	72-73
Adjustment of Title II Retroactive Benefits for Supplemental Security Income Payment	1127	501(a)	469	--	78	69
Extension Trial Work/ Disability Reentitlement	1611(e)(4)	303(c)(2)	453	7-8	51	53-54
Employment in Sheltered Workshops	1612(a)(1)(A)	202(a)(1)	449	--	47-48	51
Employment in Sheltered Workshops	1612(a)(1)(C)	202(a)(2)	449	--	47-48	51
Extra Work Expense and Severe Disability (SGA Test)	1612(b)(4)(B)	302(b)	451	7	50-51	53
Extra Work Expense and Severe Disability (SGA Test)	1614 (a)(3)(D)	302(a)(2)	450	7	50-51	53
Extension of Trial Work Period/Re-Entitlement to Benefits	1614(a)(3)(D)	303(c)(1)(B)	453	7-8	51	53-54
Extension of Trial Work Period/Re-Entitlement to Benefits	1614(a)(3)(F)	303(c)(1)(A)	453	7-8	51	53-54
Deeming Parents' Income to Disabled or Blind Children Under 18	1614(f)(2)	203(a)	449	--	48	51
Eligibility of Aliens For Supplemental Security Income	1614(f)(3)	504(a)	471	--	80-81	70-72
Benefits for Individuals Who Perform Substantial Gainful Activity (SGA) Despite Severe Medical Impairment	1616(c)(3)	201(b)(1)	446	7	44-47	49-51

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Subject	SS Act Section	P.L. Section	94 Stat.	H.Rep. 96-100	S.Rep. 96-408	H.C.Rep. 96-944
Benefits for Individuals Who Perform S.G.A. Despite Severe Medical Impairment	1619	201(a)	445	7	44-47	49-51
Medical and Social Services For Certain Handicapped Persons	1620	201(c)	446	--	44-47	49-51
SSI Eligibility of Aliens/ Deem Income and Resources Of Sponsor To Alien	1621	504(b)	471	--	80-81	70-72
Continue Benefits For Certain Persons In Vocational Rehabilitation	1631(a)(6)	301(b)	450	11-12	48-50	52
Adjust Title II Retroactive Benefits For SSI Payments	1631(b)(1)(sic)	501(c)(1)	470	--	78	69
Adjust Title II Retroactive Benefits For SSI Payments	1631(b)(2)(sic)	501(c)(2)	470	--	78	69
Information Required With Secretary's Decision of Disability	1631(c)(1)	305(b)	457	12	56-57	58
Payment For Certain Travel Expenses	1631(h)	310(b)	459	29	60	60
Elimination of Second Medicare Waiting Period	1811	103(a)(2)	444	7-8	43	47
Trust Fund Payment Of Certain Travel Expenses	1817(i)	310(c)	460	29	60	60
Elimination of Second Medicare Waiting Period	1837(g)(1)	103(a)(3)	444	7-8	43	47
Voluntary Certification Of Medicare Supplemental Health Insurance Policies	1882	507(a)	476	--	--	75-77
Restricting Disclosures Under Social Services	2003(d)(1)(B)	403(b)(1)	462	--	65-66	63-64
Restricting Disclosures Under Social Services	2003(d)(1)(B)	403(b)(2)	462	--	65-66	63-64
Restricting Disclosures Under Social Services	2003(d)(1)(B)(A)(sic)	403(b)(3)	462	--	65-66	63-64
Restricting Disclosures Under Social Services	2003(d)(1)(B)(B)(sic)	403(b)(4)	462	--	65-66	63-64

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Subject	Provisions of Law	P.L. Section	94 Stat.	H.Rep. 96-100	S.Rep. 96-408	H.C.Rep. 96-944
Elimination of Second Medicare Waiting Period	Railroad Retirement P.L. 75-162 §7(d)(2)(ii)	103(a)(4)	444	7-8	43	47
Disclosure By Social Security Administration Of Certain Information To S & L (State & Local) Child Support Enforcement Agencies	P.L. 83-591 IRC 26 USC 6103(l)(7)	408(a)(1)	468	--	71-77	66-68
Disclosure By Social Security Administration Of Certain Information To S & L Child Support Enforcement Agencies	26 USC 6103 (INT. REV.) (p)(3)(A)	408(a)(2)(A)	468	--	71-77	66-68
Disclosure By Social Security Administration Of Certain Information To S & L Child Support Enforcement Agencies	26 USC 6103 (p)(4)	408(a)(2)(B)	468	--	71-77	66-68
Disclosure By Social Security Administration Of Certain Information To S & L Child Support Enforcement Agencies	26 USC 6103 (p)(4)(F)(i)	408(a)(2)(C)	468	--	71-77	66-68
Disclosure By Social Security Administration Of Certain Information To S & L Child Support Enforcement Agencies	26 USC 7213(a) (2)	408(a)(2)(D)	468	--	71-77	66-68
Benefits For Persons Who Perform SGA Despite Severe Medical Impairment	P.L. 93-66, §212(a) Cost-of-Living & Mandatory Minimum State Support Of SSI	201(b)(2)	446	--	44-47	49-51
Extension Of National Commission On Social Security To 4/1/81	SSA 1977 Amendments P.L. 95-216 (Affects) §361(a)(2)(F)	502(a)	470	--	79	69
Extension Of National Commission On Social Security To 4/1/81	§361(c)(2)	502(b)	470	--	79	69
Separate Accounts Under Section 1619	P.L. 96-265 (Affects)	201(e)	449	7	44-47	49-51
Own Motion Review of Administrative Law Judges Decisions - Report to Congress		304(g)	456	--	52-56	57-58
Plan Submittal to Congress Re Federal Take-over Of Disability Determinations		304(i)	457	8-10	52-56	55-56

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Subject	Provisions of Law	P.L. Section	94 Stat.	H.Rep. 96-100	S.Rep. 96-408	H.C.Rep. 96-944
Time Limits For Decisions On Title II Claims--Report to Congress		308	458	14, 27	59	59
Report to Congress By Secretary Health And Human Services Re Impact Of P.L. 96-265, First 3 Titles		312	460	--	--	61
AFDC Work Requirement -- Effective Date and Regulations Due Date		401(i)	462	--	61-63	62-63
Authority For Experiments and Demonstration Projects		505(a)(1)	473	7, 23-24	82-83	72-73
Authority For Experiments and Demonstration Projects (Scope of Study)		505(a)(2)	473	7, 23-24	82-83	72-73
Authority For Experiments and Demonstration Projects (Pre-Conditions)		505(a)(3)	473	7, 23-24	82-83	72-73
Authority For Experiments and Demonstration Projects (Report to Congress)		505(a)(4)	474	7, 23-24	82-83	72-73
Authority For Experiments and Demonstration Projects (Final Report to Congress)		505(c)	475	7, 23-24	82-83	72-73
Demonstration Project Re Terminally Ill		506	475	--	81-82	74

For a narrative account of the legislative history of P.L. 96-265 and a summary of its provisions, see: Social Security Bulletin, April 1981, Vol. 44, No. 4.

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Public Law 96-265
96th Congress

An Act

June 9, 1980
[H.R. 3236]

To amend the Social Security Act to provide better work incentives and improved accountability in the disability programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Social Security Disability Amendments of 1980".

Social Security Disability Amendments of 1980.
42 USC 1305 note.

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TITLE I—PROVISIONS RELATING TO DISABILITY BENEFITS UNDER OASDI PROGRAM

LIMITATION ON TOTAL FAMILY BENEFITS IN DISABILITY CASES

42 USC 403. SEC. 101. (a) Section 203(a) of the Social Security Act is amended—

(1) by striking out "except as provided by paragraph (3)" in paragraph (1) (in the matter preceding subparagraph (A)) and inserting in lieu thereof "except as provided by paragraphs (3) and (6)";

(2) by redesignating paragraphs (6), (7), and (8) as paragraphs (7), (8), and (9), respectively; and

(3) by inserting after paragraph (5) the following new paragraph:

"(6) Notwithstanding any of the preceding provisions of this subsection other than paragraphs (3)(A), (3)(C), and (5) (but subject to section 42 USC 415. 215(i)(2)(A)(ii)), the total monthly benefits to which beneficiaries may 42 USC 402, 423. be entitled under section 202 and 223 for any month on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits, whether or not such total benefits are otherwise subject to reduction under this subsection but after any reduction under this subsection which would otherwise be applicable, shall be reduced or further reduced (before the application of section 42 USC 424a. 224) to the smaller of—

"(A) 85 percent of such individual's average indexed monthly earnings (or 100 percent of his primary insurance amount, if larger), or

"(B) 150 percent of such individual's primary insurance amount.".

42 USC 403. (b)(1) Section 203(a)(2)(D) of such Act is amended by striking out "paragraph (7)" and inserting in lieu thereof "paragraph (8)".

(2) Section 203(a)(8) of such Act, as redesignated by subsection (a)(2) of this section, is amended by striking out "paragraph (6)" and inserting in lieu thereof "paragraph (7)".

42 USC 415. (3) Section 215(a)(2)(A)(ii)(III) of such Act is amended by striking out "section 203(a)(6) and (7)" and inserting in lieu thereof "section 203(a)(7) and (8)".

(4) Section 215(i)(2)(D) of such Act is amended by adding at the end thereof the following new sentence: "Notwithstanding the preceding sentence, such revision of maximum family benefits shall be subject to paragraph (6) of section 203(a) (as added by section 101(a)(3) of the Social Security Disability Amendments of 1980).". *Supra*

(c) The amendments made by this section shall apply only with respect to monthly benefits payable on the basis of the wages and self-employment income of an individual who first becomes eligible for benefits (determined under sections 215(a)(3)(B) and 215(a)(2)(A) of the Social Security Act, as applied for this purpose) after 1978, and who first becomes entitled to disability insurance benefits after June 30, 1980. 42 USC 403 note. 42 USC 415.

REDUCTION IN NUMBER OF DROPOUT YEARS FOR YOUNGER DISABLED WORKERS

SEC. 102. (a) Section 215(b)(2)(A) of the Social Security Act is amended to read as follows: 42 USC 415.

"(2)(A) The number of an individual's benefit computation years equals the number of elapsed years reduced—

"(i) in the case of an individual who is entitled to old-age insurance benefits (except as provided in the second sentence of this subparagraph), or who has died, by 5 years, and

"(ii) in the case of an individual who is entitled to disability insurance benefits, by the number of years equal to one-fifth of such individual's elapsed years (disregarding any resulting fractional part of a year), but not by more than 5 years.

Clause (ii), once applicable with respect to any individual, shall continue to apply for purposes of determining such individual's primary insurance amount for purposes of any subsequent eligibility for disability or old-age insurance benefits unless prior to the month in which such eligibility begins there occurs a period of at least 12 consecutive months for which he was not entitled to a disability or an old-age insurance benefit. If an individual described in clause (ii) is living with a child (of such individual or his or her spouse) under the age of 3 in any calendar year which is included in such individual's computation base years, but which is not disregarded pursuant to clause (ii) or to subparagraph (B) (in determining such individual's benefit computation years) by reason of the reduction in the number of such individual's elapsed years under clause (ii), the number by which such elapsed years are reduced under this subparagraph pursuant to clause (ii) shall be increased by one (up to a combined total not exceeding 3) for each such calendar year; except that (I) no calendar year shall be disregarded by reason of this sentence (in determining such individual's benefit computation years) unless the individual was living with such child substantially throughout the period in which the child was alive and under the age of 3 in such year and the individual had no earnings as described in section 203(f)(5) in such year, (II) the particular calendar years to be disregarded under this sentence (in determining such benefit computation years) shall be those years (not otherwise disregarded under clause (ii)) which, before the application of section 215(f), meet the conditions of subclause (I), and (III) this sentence shall apply only to the extent that its application would not result in a lower primary insurance amount. The number of an individual's benefit computation years as determined under this subparagraph shall in no case be less than 2.". 42 USC 403.

(b) Section 223(a)(2) of such Act is amended by inserting "and section 215(b)(2)(A)(ii)" after "section 202(q)" in the first sentence. 42 USC 423. 42 USC 415, 402.

(c) The amendments made by this section shall apply only with respect to monthly benefits payable on the basis of the wages and self-employment income of an individual who first becomes entitled to disability insurance benefits on or after July 1, 1980; except that the 42 USC 415 note.

third sentence of section 215(b)(2)(A) of the Social Security Act (as added by such amendments) shall apply only with respect to monthly benefits payable for months beginning on or after July 1, 1981.

PROVISIONS RELATING TO MEDICARE WAITING PERIOD FOR RECIPIENTS OF DISABILITY BENEFITS

42 USC 426

SEC. 103. (a)(1)(A) Section 226(b)(2) of the Social Security Act is amended by striking out "consecutive" in clauses (A) and (B).

(B) Section 226(b) of such Act is further amended by striking out "consecutive" in the matter following paragraph (2).

42 USC 1395c

(2) Section 1811 of such Act is amended by striking out "consecutive".

42 USC 1395p

(3) Section 1837(g)(1) of such Act is amended by striking out "consecutive".

45 USC 231f

(4) Section 7(d)(2)(ii) of the Railroad Retirement Act of 1974 is amended by striking out "consecutive" each place it appears.

42 USC 426

(b) Section 226 of the Social Security Act is amended by redesignating subsection (f) as subsection (g), and by inserting after subsection (e) the following new subsection:

"(f) For purposes of subsection (b) (and for purposes of section 1837(g)(1) of this Act and section 7(d)(2)(ii) of the Railroad Retirement Act of 1974), the 24 months for which an individual has to have been entitled to specified monthly benefits on the basis of disability in order to become entitled to hospital insurance benefits on such basis effective with any particular month (or to be deemed to have enrolled in the supplementary medical insurance program, on the basis of such entitlement, by reason of section 1837(f)), where such individual had been entitled to specified monthly benefits of the same type during a previous period which terminated—

"(1) more than 60 months before the month in which his current disability began in any case where such monthly benefits were of the type specified in clause (A)(i) or (B) of subsection (b)(2), or

"(2) more than 84 months before the month in which his current disability began in any case where such monthly benefits were of the type specified in clause (A)(ii) or (A)(iii) of such subsection,

shall not include any month which occurred during such previous period.".

42 USC 426 note

(c) The amendments made by this section shall apply with respect to hospital insurance or supplementary medical insurance benefits for services provided on or after the first day of the sixth month which begins after the date of the enactment of this Act.

CONTINUATION OF MEDICARE ELIGIBILITY

42 USC 426

SEC. 104. (a) Section 226(b) of the Social Security Act is amended—

(1) by striking out "ending with the month" in the matter following paragraph (2) and inserting in lieu thereof "ending (subject to the last sentence of this subsection) with the month", and

(2) by adding at the end thereof the following new sentence: "For purposes of this subsection, an individual who has had a period of trial work which ended as provided in section 222(c)(4)(A), and whose entitlement to benefits or status as a qualified railroad retirement beneficiary as described in para-

42 USC 422

graph (2) has subsequently terminated, shall be deemed to be entitled to such benefits or to occupy such status (notwithstanding the termination of such entitlement or status) for the period of consecutive months throughout all of which the physical or mental impairment, on which such entitlement or status was based, continues, and throughout all of which such individual would have been entitled to monthly insurance benefits under title II or as a qualified railroad retirement beneficiary had such individual been unable to engage in substantial gainful activity, but not in excess of 24 such months.". 42 USC 401.

(b) The amendments made by subsection (a) shall become effective on the first day of the sixth month which begins after the date of the enactment of this Act, and shall apply with respect to any individual whose disability has not been determined to have ceased prior to such first day. Effective date. 42 USC 426 note.

TITLE II—PROVISIONS RELATING TO DISABILITY BENEFITS UNDER THE SSI PROGRAM

BENEFITS FOR INDIVIDUALS WHO PERFORM SUBSTANTIAL GAINFUL ACTIVITY DESPITE SEVERE MEDICAL IMPAIRMENT

SEC. 201. (a) Part A of title XVI of the Social Security Act is amended by adding at the end thereof the following new section:

"BENEFITS FOR INDIVIDUALS WHO PERFORM SUBSTANTIAL GAINFUL ACTIVITY DESPITE SEVERE MEDICAL IMPAIRMENT

"SEC. 1619. (a) Any individual who is an eligible individual (or eligible spouse) by reason of being under a disability and was eligible to receive benefits under section 1611(b) or under this section for the month preceding the month for which eligibility for benefits under this section is now being determined, and who would otherwise be denied benefits by reason of section 1611(e)(4) or ceases to be an eligible individual (or eligible spouse) because his earnings have demonstrated a capacity to engage in substantial gainful activity, shall nevertheless qualify for a monthly benefit equal to an amount determined under section 1611(b)(1) (or, in the case of an individual who has an eligible spouse, under section 1611(b)(2)), and for purposes of titles XIX and XX of this Act shall be considered a disabled individual receiving supplemental security income benefits under this title, for so long as the Secretary determines that— 42 USC 1382h. 42 USC 1382. 42 USC 1396, 1397.

"(1) such individual continues to have the disabling physical or mental impairment on the basis of which such individual was found to be under a disability, and continues to meet all non-disability-related requirements for eligibility for benefits under this title; and

"(2) the income of such individual, other than income excluded pursuant to section 1612(b), is not equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments). 42 USC 1382a.

"(b) For purposes of titles XIX and XX, any individual under age 65 who, for the month preceding the first month in the period to which this subsection applies, received—

"(i) a payment of supplemental security income benefits under section 1611(b) on the basis of blindness or disability,

"(ii) a supplementary payment under section 1616 of this Act or under section 212 of Public Law 93-66 on such basis,

"(iii) a payment of monthly benefits under subsection (a), or

"(iv) a supplementary payment under section 1616(c)(3),

shall be considered to be a blind or disabled individual receiving supplemental security income benefits for so long as the Secretary determines under regulations that—

"(1) such individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under this title;

"(2) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments);

"(3) the termination of eligibility for benefits under title XIX or XX would seriously inhibit his ability to continue his employment; and

"(4) such individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under this title and titles XIX and XX which would be available to him in the absence of such earnings.".

42 USC 1382e (b)(1) Section 1616(c) of such Act is amended by adding at the end thereof the following new paragraph:

"(3) Any State (or political subdivision) making supplementary payments described in subsection (a) shall have the option of making such payments to individuals who receive benefits under this title under the provisions of section 1619, or who would be eligible to receive such benefits but for their income.".

42 USC 1382 note (2) Section 212(a) of Public Law 93-66 is amended by adding at the end thereof the following new paragraph:

"(4) Any State having an agreement with the Secretary under paragraph (1) may, at its option, include individuals receiving benefits under section 1619 of the Social Security Act, or who would be eligible to receive such benefits but for their income, under the agreement as though they are aged, blind, or disabled individuals as specified in paragraph (2)(A).".

(c) Part A of title XVI of the Social Security Act is amended by adding at the end thereof (after the new section added by subsection (a) of this section) the following new section:

Ante, p. 145.

Ante, p. 145.

"MEDICAL AND SOCIAL SERVICES FOR CERTAIN HANDICAPPED PERSONS

42 USC 1382i "SEC. 1620. (a) There are authorized to be appropriated such sums as may be necessary to establish and carry out a 3-year Federal-State pilot program to provide medical and social services for certain handicapped individuals in accordance with this section.

"(b)(1) The total sum of $18,000,000 shall be allotted to the States for such program by the Secretary, during the period beginning September 1, 1981, and ending September 30, 1984, as follows:

"(A) The total sum of $6,000,000 shall be allotted to the States for the fiscal year ending September 30, 1982 (which for purposes of this section shall include the month of September 1981).

"(B) The total sum of $6,000,000, plus any amount remaining available (after the application of paragraph (4)) from the allot-

ment made under subparagraph (A), shall be allotted to the States for the fiscal year ending September 30, 1983.

"(C) The total sum of $6,000,000, plus any amount remaining available (after the application of paragraph (4)) from the allotments made under subparagraphs (A) and (B), shall be allotted to the States for the fiscal year ending September 30, 1984.

"(2) The allotment to each State from the total sum allotted under paragraph (1) for any fiscal year shall bear the same ratio to such total sum as the number of individuals in such State who are over age 17 and under age 65 and are receiving supplemental security income benefits as disabled individuals in such year (as determined by the Secretary on the basis of the most recent data available) bears to the total number of such individuals in all the States. For purposes of the preceding sentence, the term 'supplemental security income benefits' includes payments made pursuant to an agreement under section 1616(a) of this Act or under section 212(b) of Public Law 93-66. "Supplemental security income benefits."

42 USC 1382e. 87 Stat. 155.

"(3) At the beginning of each fiscal year in which the pilot program under this section is in effect, each State that does not intend to use the allotment to which it is entitled for such year (or any allotment which was made to it for a prior fiscal year), or that does not intend to use the full amount of any such allotment, shall certify to the Secretary the amount of such allotment which it does not intend to use, and the State's allotment for the fiscal year (or years) involved shall thereupon be reduced by the amount so certified. Certification to Secretary.

"(4) The portion of the total amount available for allotment for any particular fiscal year under paragraph (1) which is not allotted to States for that year by reason of paragraph (3) (plus the amount of any reductions made at the beginning of such year in the allotments of States for prior fiscal years under paragraph (3)) shall be reallocated in such manner as the Secretary may determine to be appropriate to States which need, and will use, additional assistance in providing services to severely handicapped individuals in that particular year under their approved plans. Any amount reallocated to a State under this paragraph for use in a particular fiscal year shall be treated for purposes of this section as increasing such State's allotment for that year by an equivalent amount. Reallocation.

"(c) In order to participate in the pilot program and be eligible to receive payments for any period under subsection (d), a State (during such period) must have a plan, approved by the Secretary as meeting the requirements of this section, which provides medical and social services for severely handicapped individuals whose earnings are above the level which ordinarily demonstrates an ability to engage in substantial gainful activity and who are not receiving benefits under section 1611 or 1619 or assistance under a State plan approved under section 1902, and which— 42 USC 1382. *Ante*, p. 445. 42 USC 1396a.

"(1) declares the intent of the State to participate in the pilot program;

"(2) designates an appropriate State agency to administer or supervise the administration of the program in the State;

"(3) describes the criteria to be applied by the State in determining the eligibility of any individual for assistance under the plan and in any event requires a determination by the State agency to the effect that (A) such individual's ability to continue his employment would be significantly inhibited without such assistance and (B) such individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the

cash and other benefits that would be available to him under this title and titles XIX and XX in the absence of those earnings;

42 USC 1381-1396c

"(4) describes the process by which the eligibility of individuals for such assistance is to be determined (and such process may not involve the performance of functions by any State agency or entity which is engaged in making determinations of disability for purposes of disability insurance or supplemental security income benefits except when the use of a different agency or entity to perform those functions would not be feasible);

"(5) describes the medical and social services to be provided under the plan;

"(6) describes the manner in which the medical and social services involved are to be provided and, if they are not to be provided through the State's medical assistance and social services programs under titles XIX and XX (with the Federal payments being made under subsection (d) of this section rather than under those titles), specifies the particular mechanisms and procedures to be used in providing such services; and

"(7) contains such other provisions as the Secretary may find to be necessary or appropriate to meet the requirements of this section or otherwise carry out its purpose.

The plan under this section may be developed and submitted as a separate State plan, or may be submitted in the form of an amendment to the State's plan under section 2003(d)(1).

42 USC 1397b.

"(d)(1) From its allotment under subsection (b) for any fiscal year (and any amounts remaining available from allotments made to it for prior fiscal years), the Secretary shall from time to time pay to each State which has a plan approved under subsection (c) an amount equal to 75 per centum of the total sum expended under such plan (including the cost of administration of such plan) in providing medical and social services to severely handicapped individuals who are eligible for such services under the plan.

"(2) The method of computing and making payments under this section shall be as follows:

"(A) The Secretary shall, prior to each period for which a payment is to be made to a State, estimate the amount to be paid to the State for such period under the provisions of this section.

"(B) From the allotment available therefor, the Secretary shall pay the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this subsection) by which he finds that his estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid to the State for such period under this section.

Regulations

"(e) Within nine months after the date of the enactment of this section, the Secretary shall prescribe and publish such regulations as may be necessary or appropriate to carry out the pilot program and otherwise implement this section.

Reports to Secretary and Congress

"(f) Each State participating in the pilot program under this section shall from time to time report to the Secretary on the operation and results of such program in that State, with particular emphasis upon the work incentive effects of the program. On or before October 1, 1983, the Secretary shall submit to the Congress a report on the program, incorporating the information contained in the State reports along with his findings and recommendations.".

(d) The amendments made by subsections (a) and (b) shall become effective on January 1, 1981, but shall remain in effect only for a period of three years after such effective date. Effective date. 42 USC 1382h note.

(e) The Secretary shall provide for separate accounts with respect to the benefits payable by reason of the amendments made by subsections (a) and (b) so as to provide for evaluation of the effects of such amendments on the programs established by titles II, XVI, XIX, and XX of the Social Security Act. 42 USC 1382h note. 42 USC 401, 1381, 1396, 1397.

EARNED INCOME IN SHELTERED WORKSHOPS

SEC. 202. (a) Section 1612(a)(1) of the Social Security Act is amended— 42 USC 1382a.

(1) by striking out "and" after the semicolon at the end of subparagraph (A); and

(2) by adding after subparagraph (B) the following new subparagraph:

"(C) remuneration received for services performed in a sheltered workshop or work activities center; and".

(b) The amendments made by subsection (a) shall apply only with respect to remuneration received in months after September 1980. 42 USC 1382a note.

TERMINATION OF ATTRIBUTION OF PARENTS' INCOME AND RESOURCES WHEN CHILD ATTAINS AGE 18

SEC. 203. (a) Section 1614(f)(2) of the Social Security Act is amended by striking out "under age 21" and inserting in lieu thereof "under age 18". 42 USC 1382c.

(b) The amendment made by subsection (a) shall become effective on October 1, 1980; except that the amendment made by such subsection shall not apply, in the case of any child who, in September 1980, was 18 or over and received a supplemental security income benefit for such month, during any period for which such benefit would be greater without the application of such amendment. Effective date. 42 USC 1382c note.

TITLE III—PROVISIONS AFFECTING DISABILITY RECIPIENTS UNDER OASDI AND SSI PROGRAMS; ADMINISTRATIVE PROVISIONS

CONTINUED PAYMENT OF BENEFITS TO INDIVIDUALS UNDER VOCATIONAL REHABILITATION PLANS

SEC. 301. (a)(1) Section 225 of the Social Security Act is amended by inserting "(a)" after "SEC. 225.", and by adding at the end thereof the following new subsection: 42 USC 425.

"(b) Notwithstanding any other provision of this title, payment to an individual of benefits based on disability (as described in the first sentence of subsection (a)) shall not be terminated or suspended because the physical or mental impairment, on which the individual's entitlement to such benefits is based, has or may have ceased, if—

"(1) such individual is participating in an approved vocational rehabilitation program under a State plan approved under title I of the Rehabilitation Act of 1973, and 29 USC 720

"(2) the Commissioner of Social Security determines that the completion of such program, or its continuation for a specified period of time, will increase the likelihood that such individual

may (following his participation in such program) be permanently removed from the disability benefit rolls.".

(2) Section 225(a) of such Act (as designated under subsection (a) of this section) is amended by striking out "this section" each place it appears and inserting in lieu thereof "this subsection".

(b) Section 1631(a) of such Act is amended by adding at the end thereof the following new paragraph:

"(6) Notwithstanding any other provision of this title, payment of the benefit of any individual who is an aged, blind, or disabled individual solely by reason of disability (as determined under section 1614(a)(3)) shall not be terminated or suspended because the physical or mental impairment, on which the individual's eligibility for such benefit is based, has or may have ceased, if—

"(A) such individual is participating in an approved vocational rehabilitation program under a State plan approved under title I of the Rehabilitation Act of 1973, and

"(B) the Commissioner of Social Security determines that the completion of such program, or its continuation for a specified period of time, will increase the likelihood that such individual may (following his participation in such program) be permanently removed from the disability benefit rolls.".

Effective date.

(c) The amendments made by this section shall become effective on the first day of the sixth month which begins after the date of the enactment of this Act, and shall apply with respect to individuals whose disability has not been determined to have ceased prior to such first day.

EXTRAORDINARY WORK EXPENSES DUE TO SEVERE DISABILITY

SEC. 302. (a)(1) Section 223(d)(4) of the Social Security Act is amended by inserting after the third sentence the following new sentence: "In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, there shall be excluded from such earnings an amount equal to the cost (to such individual) of any attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Secretary in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the amounts to be excluded shall be subject to such reasonable limits as the Secretary may prescribe.".

(2) Section 1614(a)(3)(D) of such Act is amended by inserting after the first sentence the following new sentence: "In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, there shall be excluded from such earnings an amount equal to the cost (to such individual) of any attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Secretary in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the

amounts to be excluded shall be subject to such reasonable limits as the Secretary may prescribe.".

(b) Section 1612(b)(4)(B) of such Act is amended by striking out "plus one-half of the remainder thereof, and (ii)" and inserting in lieu thereof the following: "(ii) such additional amounts of earned income of such individual (for purposes of determining the amount of his or her benefits under this title and of determining his or her eligibility for such benefits for consecutive months of eligibility after the initial month of such eligibility), if such individual's disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, as may be necessary to pay the costs (to such individual) of attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Secretary in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions, except that the amounts to be excluded shall be subject to such reasonable limits as the Secretary may prescribe, (iii) one-half of the amount of earned income not excluded after the application of the preceding provisions of this subparagraph, and (iv)". 42 USC 1382a.

(c) The amendments made by this section shall apply with respect to expenses incurred on or after the first day of the sixth month which begins after the date of the enactment of this Act. 42 USC 423 note.

REENTITLEMENT TO DISABILITY BENEFITS

SEC. 203. (a)(1) Section 222(c)(1) of the Social Security Act is amended by striking out "section 223 or 202(d)" and inserting in lieu thereof "section 223, 202(d), 202(e), or 202(f)". 42 USC 422. 42 USC 423, 402.

(2) Section 222(c)(3) of such Act is amended by striking out the period at the end of the first sentence and inserting in lieu thereof ", or, in the case of an individual entitled to widow's or widower's insurance benefits under section 202 (e) or (f) who became entitled to such benefits prior to attaining age 60, with the month in which such individual becomes so entitled.".

(b)(1)(A) Section 223(a)(1) of such Act is amended by striking out "or the third month following the month in which his disability ceases." at the end of the first sentence and inserting in lieu thereof "or, subject to subsection (e), the termination month. For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 15 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity.".

(B) Section 202(d)(1)(G) of such Act is amended—

(i) by redesignating clauses (i) and (ii) as clauses (III) and (IV), respectively, and

(ii) by striking out "the third month following the month in which he ceases to be under such disability" and inserting in lieu thereof ", or, subject to section 223(e), the termination month (and for purposes of this subparagraph, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 15 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity,".

(C) Section 202(e)(1) of such Act is amended by striking out "the third month following the month in which her disability ceases (unless she attains age 65 on or before the last day of such third month)." at the end thereof and inserting in lieu thereof ", subject to section 223(e), the termination month (unless she attains age 65 on or before the last day of such termination month). For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which her disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 15 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity.".

(D) Section 202(f)(1) of such Act is amended by striking out "the third month following the month in which his disability ceases (unless he attains age 65 on or before the last day of such third month)." at the end thereof and inserting in lieu thereof ", subject to section 223(e), the termination month (unless he attains age 65 on or before the last day of such termination month). For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 15 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity.".

(2)(A) Section 223 of such Act is amended by adding at the end thereof the following new subsection: 42 USC 423.

"(e) No benefit shall be payable under subsection (d)(1)(B)(ii), (e)(1)(B)(ii), or (f)(1)(B)(ii) of section 202 or under subsection (a)(1) of this section to an individual for any month, after the third month, in which he engages in substantial gainful activity during the 15-month period following the end of his trial work period determined by application of section 222(c)(4)(A).". 42 USC 402. 42 USC 422.

(B) Section 216(i)(2)(D) of such Act is amended by striking out "(ii)" and all that follows and inserting in lieu thereof "(ii) the month preceding (I) the termination month (as defined in section 223(a)(1)), or, if earlier (II) the first month for which no benefit is payable by reason of section 223(e), where no benefit is payable for any of the succeeding months during the 15-month period referred to in such section." 42 USC 416.

(c)(1)(A) Section 1614(a)(3) of such Act is amended by adding at the end thereof the following new subparagraph: 42 USC 1382c.

"(F) For purposes of this title, an individual whose trial work period has ended by application of paragraph (4)(D)(i) shall, subject to section 1611(e)(4), nonetheless be considered (except for purposes of section 1631(a)(5)) to be disabled through the end of the month preceding the termination month. For purposes of the preceding sentence, the termination month for any individual shall be the earlier of (i) the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (ii) the first month, after the period of 15 consecutive months following the end of such period of trial work, in which such individual engages in or is determined to be able to engage in substantial gainful activity.". 42 USC 1382. 42 USC 1383.

(B) Section 1614(a)(3)(D) of such Act is amended by striking out "paragraph (4)" and inserting in lieu thereof "subparagraph (F) or paragraph (4)". *Ante*, p. 450.

(2) Section 1611(e) of such Act is amended by adding at the end thereof the following new paragraph:

"(4) No benefit shall be payable under this title, except as provided in section 1619 (or section 1616(c)(3)), with respect to an eligible individual or his eligible spouse who is an aged, blind, or disabled individual solely by application of section 1614(a)(3)(F) for any month, after the third month, in which he engages in substantial gainful activity during the fifteen-month period following the end of his trial work period determined by application of section 1614(a)(4)(D)(i).". *Ante*, pp. 445, 446. *Supra*.

(d) The amendments made by this section shall become effective on the first day of the sixth month which begins after the date of the enactment of this Act, and shall apply with respect to any individual whose disability has not been determined to have ceased prior to such first day. Effective date. 42 USC 402 note.

DISABILITY DETERMINATIONS; FEDERAL REVIEW OF STATE AGENCY DETERMINATIONS

SEC. 304. (a) Section 221(a) of the Social Security Act is amended to read as follows: 42 USC 421.

"(a)(1) In the case of any individual, the determination of whether or not he is under a disability (as defined in section 216(i) or 223(d)) and of the day such disability began, and the determination of the day on which such disability ceases, shall be made by a State agency, notwithstanding any other provision of law, in any State that notifies 42 USC 416, 423.

the Secretary in writing that it wishes to make such disability determinations commencing with such month as the Secretary and the State agree upon, but only if (A) the Secretary has not found, under subsection (b)(1), that the State agency has substantially failed to make disability determinations in accordance with the applicable provisions of this section or rules issued thereunder, and (B) the State has not notified the Secretary, under subsection (b)(2), that it does not wish to make such determinations. If the Secretary once makes the finding described in clause (A) of the preceding sentence, or the State gives the notice referred to in clause (B) of such sentence, the Secretary may thereafter determine whether (and, if so, beginning with which month and under what conditions) the State may again make disability determinations under this paragraph.

"(2) The disability determinations described in paragraph (1) made by a State agency shall be made in accordance with the pertinent provisions of this title and the standards and criteria contained in regulations or other written guidelines of the Secretary pertaining to matters such as disability determinations, the class or classes of individuals with respect to which a State may make disability determinations (if it does not wish to do so with respect to all individuals in the State), and the conditions under which it may choose not to make all such determinations. In addition, the Secretary shall promulgate regulations specifying, in such detail as he deems appropriate, performance standards and administrative requirements and procedures to be followed in performing the disability determination function in order to assure effective and uniform administration of the disability insurance program throughout the United States. The regulations may, for example, specify matters such as— Regulations

"(A) the administrative structure and the relationship between various units of the State agency responsible for disability determinations,

"(B) the physical location of and relationship among agency staff units, and other individuals or organizations performing tasks for the State agency, and standards for the availability to applicants and beneficiaries of facilities for making disability determinations,

"(C) State agency performance criteria, including the rate of accuracy of decisions, the time periods within which determinations must be made, the procedures for and the scope of review by the Secretary, and, as he finds appropriate, by the State, of its performance in individual cases and in classes of cases, and rules governing access of appropriate Federal officials to State offices and to State records relating to its administration of the disability determination function,

"(D) fiscal control procedures that the State agency may be required to adopt, and

"(E) the submission of reports and other data, in such form and at such time as the Secretary may require, concerning the State agency's activities relating to the disability determination.

Nothing in this section shall be construed to authorize the Secretary to take any action except pursuant to law or to regulations promulgated pursuant to law.".

42 USC 421 Disability determinations

(b) Section 221(b) of such Act is amended to read as follows:

"(b)(1) If the Secretary finds, after notice and opportunity for a hearing, that a State agency is substantially failing to make disability determinations in a manner consistent with his regulations and other

written guidelines, the Secretary shall, not earlier than 180 days following his finding, and after he has complied with the requirements of paragraph (3), make the disability determinations referred to in subsection (a)(1).

Notification to Secretary

"(2) If a State, having notified the Secretary of its intent to make disability determinations under subsection (a)(1), no longer wishes to make such determinations, it shall notify the Secretary in writing of that fact, and, if an agency of the State is making disability determinations at the time such notice is given, it shall continue to do so for not less than 180 days, or (if later) until the Secretary has complied with the requirements of paragraph (3). Thereafter, the Secretary shall make the disability determinations referred to in subsection (a)(1).

Assumption of State agency function

"(3)(A) The Secretary shall develop and initiate all appropriate procedures to implement a plan with respect to any partial or complete assumption by the Secretary of the disability determination function from a State agency, as provided in this section, under which employees of the affected State agency who are capable of performing duties in the disability determination process for the Secretary shall, notwithstanding any other provision of law, have a preference over any other individual in filling an appropriate employment position with the Secretary (subject to any system established by the Secretary for determining hiring priority among such employees of the State agency) unless any such employee is the administrator, the deputy administrator, or assistant administrator (or his equivalent) of the State agency, in which case the Secretary may accord such priority to such employee.

State agency employees, determination by Secretary of Labor

"(B) The Secretary shall not make such assumption of the disability determination function until such time as the Secretary of Labor determines that, with respect to employees of such State agency who will be displaced from their employment on account of such assumption by the Secretary and who will not be hired by the Secretary to perform duties in the disability determination process, the State has made fair and equitable arrangements to protect the interests of employees so displaced. Such protective arrangements shall include only those provisions which are provided under all applicable Federal, State and local statutes including, but not limited to, (i) the preservation of rights, privileges, and benefits (including continuation of pension rights and benefits) under existing collective-bargaining agreements; (ii) the continuation of collective-bargaining rights; (iii) the assignment of affected employees to other jobs or to retraining programs; (iv) the protection of individual employees against a worsening of their positions with respect to their employment; (v) the protection of health benefits and other fringe benefits; and (vi) the provision of severance pay, as may be necessary.".

(c) Section 221(c) of such Act is amended to read as follows: 42 USC 421

Review

"(c)(1) The Secretary may on his own motion or as required under paragraphs (2) and (3) review a determination, made by a State agency under this section, that an individual is or is not under a disability (as defined in section 216(i) or 223(d)) and, as a result of such review, may modify such agency's determination and determine that such individual either is or is not under a disability (as so defined) or that such individual's disability began on a day earlier or later than that determined by such agency, or that such disability ceased on a day earlier or later than that determined by such agency. A review by the Secretary on his own motion of a State agency determination

42 USC 416, 423

under this paragraph may be made before or after any action is taken to implement such determination.

"(2) The Secretary (in accordance with paragraph (3)) shall review determinations, made by State agencies pursuant to this section, that individuals are under disabilities (as defined in section 216(i) or 223(d)). Any review by the Secretary of a State agency determination under this paragraph shall be made before any action is taken to implement such determination.

"(3) In carrying out the provisions of paragraph (2) with respect to the review of determinations, made by State agencies pursuant to this section, that individuals are under disabilities (as defined in section 216(i) or 223(d)), the Secretary shall review—

"(A) at least 15 percent of all such determinations made by State agencies in the fiscal year 1981,

"(B) at least 35 percent of all such determinations made by State agencies in the fiscal year 1982, and

"(C) at least 65 percent of all such determinations made by State agencies in any fiscal year after the fiscal year 1982.".

(d) Section 221(d) of such Act is amended by striking out "(a)" and inserting in lieu thereof "(a), (b)".

(e) The first sentence of section 221(e) of such Act is amended—

(1) by striking out "which has an agreement with the Secretary" and inserting in lieu thereof "which is making disability determinations under subsection (a)(1)",

(2) by striking out "as may be mutually agreed upon" and inserting in lieu thereof "as determined by the Secretary", and

(3) by striking out "carrying out the agreement under this section" and inserting in lieu thereof "making disability determinations under subsection (a)(1)".

(f) Section 221(g) of such Act is amended—

(1) by striking out "has no agreement under subsection (b)" and inserting in lieu thereof "does not undertake to perform disability determinations under subsection (a)(1), or which has been found by the Secretary to have substantially failed to make disability determinations in a manner consistent with his regulations and guidelines", and

(2) by striking out "not included in an agreement under subsection (b)" and inserting in lieu thereof "for whom no State undertakes to make disability determinations".

Report to Congress.
42 USC 421 note.

(g) The Secretary of Health and Human Services shall implement a program of reviewing, on his own motion, decisions rendered by administrative law judges as a result of hearings under section 221(d) of the Social Security Act, and shall report to the Congress by January 1, 1982, on his progress.

Effective date.
42 USC 421 note.

(h) The amendments made by subsections (a), (b), (d), (e), and (f) shall be effective beginning with the twelfth month following the month in which this Act is enacted. Any State that, on the effective date of the amendments made by this section, has in effect an agreement with the Secretary of Health and Human Services under section 221(a) of the Social Security Act (as in effect prior to such amendments) will be deemed to have given to the Secretary the notice specified in section 221(a)(1) of such Act as amended by this section, in lieu of continuing such agreement in effect after the effective date of such amendments. Thereafter, a State may notify the Secretary in writing that it no longer wishes to make disability determinations, effective not less than 180 days after the notification is given.

State agreements with Secretary of Health and Human Services, notification.

(i) The Secretary of Health and Human Services shall submit to the Congress by July 1, 1980, a detailed plan on how he expects to assume the functions and operations of a State disability determination unit when this becomes necessary under the amendments made by this section, and how he intends to meet the requirements of section 221(b)(3) of the Social Security Act. Such plan should assume the uninterrupted operation of the disability determination function and the utilization of the best qualified personnel to carry out such function. If any amendment of Federal law or regulation is required to carry out such plan, recommendations for such amendment should be included in the report.

Plan, submittal to Congress.
42 USC 421 note.
42 USC 421.

INFORMATION TO ACCOMPANY SECRETARY'S DECISIONS

SEC. 305. (a) Section 205(b) of the Social Security Act is amended by inserting after the first sentence the following new sentence: "Any such decision by the Secretary which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the Secretary's determination and the reason or reasons upon which it is based.".

42 USC 405.

(b) Section 1631(c)(1) of such Act is amended by inserting after the first sentence thereof the following new sentence: "Any such decision by the Secretary which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the Secretary's determination and the reason or reasons upon which it is based.".

42 USC 1383.

(c) The amendments made by this section shall apply with respect to decisions made on or after the first day of the 13th month following the month in which this Act is enacted.

42 USC 405 note.

LIMITATION ON PROSPECTIVE EFFECT OF APPLICATION

SEC. 306. (a) Section 202(j)(2) of the Social Security Act is amended to read as follows:

42 USC 402.

"(2) An application for any monthly benefits under this section filed before the first month in which the applicant satisfies the requirements for such benefits shall be deemed a valid application (and shall be deemed to have been filed in such first month) only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application and no request under section 205(b) for notice and opportunity for a hearing thereon is made or, if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Secretary).".

42 USC 405.

(b) Section 216(i)(2)(G) of such Act is amended—

42 USC 416.

(1) by inserting "(and shall be deemed to have been filed on such first day)" immediately after "shall be deemed a valid application" in the first sentence,

(2) by striking out the period at the end of the first sentence and inserting in lieu thereof "and no request under section 205(b) for notice and opportunity for a hearing thereon is made or, if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Secretary).", and

(3) by striking out the second sentence.

42 USC 423 (c) Section 223(b) of such Act is amended—

(1) by inserting "(and shall be deemed to have been filed in such first month)" immediately after "shall be deemed a valid application" in the first sentence,

(2) by striking out the period at the end of the first sentence and inserting in lieu thereof "and no request under section 205(b) for notice and opportunity for a hearing thereon is made, or if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Secretary)", and

(3) by striking out the second sentence.

42 USC 402 note (d) The amendments made by this section shall apply to applications filed after the month in which this Act is enacted.

LIMITATION ON COURT REMANDS

42 USC 405 SEC. 307. The sixth sentence of section 205(g) of the Social Security Act is amended by striking out all that precedes "and the Secretary shall" and inserting in lieu thereof the following: "The court may, on motion of the Secretary made for good cause shown before he files his answer, remand the case to the Secretary for further action by the Secretary, and it may at any time order additional evidence to be taken before the Secretary, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding;".

TIME LIMITATIONS FOR DECISIONS ON BENEFIT CLAIMS

Report to Congress. 42 USC 401 note. 42 USC 401. SEC. 308. The Secretary of Health and Human Services shall submit to the Congress, no later than July 1, 1980, a report recommending the establishment of appropriate time limitations governing decisions on claims for benefits under title II of the Social Security Act. Such report shall specifically recommend—

(1) the maximum period of time (after application for a payment under such title is filed) within which the initial decision of the Secretary as to the rights of the applicant should be made;

(2) the maximum period of time (after application for reconsideration of any decision described in paragraph (1) is filed) within which a decision of the Secretary on such reconsideration should be made;

(3) the maximum period of time (after a request for a hearing with respect to any decision described in paragraph (1) is filed) within which a decision of the Secretary upon such hearing (whether affirming, modifying, or reversing such decision) should be made; and

(4) the maximum period of time (after a request for review by the Appeals Council with respect to any decision described in paragraph (1) is made) within which the decision of the Secretary upon such review (whether affirming, modifying, or reversing such decision) should be made.

In determining the time limitations to be recommended, the Secretary shall take into account both the need for expeditious processing of claims for benefits and the need to assure that all such claims will be thoroughly considered and accurately determined.

PAYMENT FOR EXISTING MEDICAL EVIDENCE

SEC. 309. (a) Section 223(d)(5) of the Social Security Act is amended by adding at the end thereof the following new sentence: "Any non-Federal hospital, clinic, laboratory, or other provider of medical services, or physician not in the employ of the Federal Government, which supplies medical evidence required and requested by the Secretary under this paragraph shall be entitled to payment from the Secretary for the reasonable cost of providing such evidence.". 42 USC 423.

(b) The amendment made by subsection (a) shall apply with respect to evidence requested on or after the first day of the sixth month which begins after the date of the enactment of this Act. 42 USC 423 note.

PAYMENT OF CERTAIN TRAVEL EXPENSES

SEC. 310. (a) Section 201 of the Social Security Act is amended by adding at the end thereof the following new subsection: 42 USC 401.

"(j) There are authorized to be made available for expenditure, out of the Federal Old-Age and Survivors Insurance Trust Fund, or the Federal Disability Insurance Trust Fund (as determined appropriate by the Secretary), such amounts as are required to pay travel expenses, either on an actual cost or commuted basis, to individuals for travel incident to medical examinations requested by the Secretary in connection with disability determinations under this title, and to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 210(i)) 42 USC 410. to attend reconsideration interviews and proceedings before administrative law judges with respect to any determination under this title. The amount available under the preceding sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Secretary) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations.".

(b) Section 1631 of such Act is amended by adding at the end thereof the following new subsection: 42 USC 1383.

"Payment of Certain Travel Expenses

"(h) The Secretary shall pay travel expenses, either on an actual cost or commuted basis, to individuals for travel incident to medical examinations requested by the Secretary in connection with disability determinations under this title, and to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 1614(e)) to attend reconsideration 42 USC 1382c. interviews and proceedings before administrative law judges with respect to any determination under this title. The amount available under the preceding sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Secretary) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the

points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations.".

42 USC 1395i. (c) Section 1817 of such Act is amended by adding at the end thereof the following new subsection:

Travel expenses, authorized trust fund payments.

"(i) There are authorized to be made available for expenditure out of the Trust Fund such amounts as are required to pay travel expenses, either on an actual cost or commuted basis, to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 210(i)) to attend reconsideration interviews and proceedings before administrative law judges with respect to any determination under this title. The amount available under the preceding sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Secretary) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations.".

42 USC 410.

PERIODIC REVIEW OF DISABILITY DETERMINATIONS

42 USC 421. SEC. 311. (a) Section 221 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(i) In any case where an individual is or has been determined to be under a disability, the case shall be reviewed by the applicable State agency or the Secretary (as may be appropriate), for purposes of continuing eligibility, at least once every 3 years; except that where a finding has been made that such disability is permanent, such reviews shall be made at such times as the Secretary determines to be appropriate. Reviews of cases under the preceding sentence shall be in addition to, and shall not be considered as a substitute for, any other reviews which are required or provided for under or in the administration of this title.".

Effective date. 42 USC 421 note. (b) The amendment made by subsection (a) shall become effective on January 1, 1982.

REPORT BY SECRETARY

Submittal to Congress. 42 USC 401 note. SEC. 312. The Secretary of Health and Human Services shall submit to the Congress not later than January 1, 1985, a full and complete report as to the effects produced by reason of the preceding provisions of this Act and the amendments made thereby.

TITLE IV—PROVISIONS RELATING TO AFDC AND CHILD SUPPORT PROGRAMS

WORK REQUIREMENT UNDER THE AFDC PROGRAM

42 USC 602. SEC. 401. (a) Section 402(a)(19)(A) of the Social Security Act is amended—

(1) by striking out all that follows "(A)" and precedes clause (i), and inserting in lieu thereof the following: "that every individual, as a condition of eligibility for aid under this part, shall

register for manpower services, training, employment, and other employment-related activities (including employment search, not to exceed eight weeks in total in each year) with the Secretary of Labor as provided by regulations issued by him, unless such individual is—";

(2) by striking out "or" at the end of clause (v);

(3) by striking out "under section 433(g)" in clause (vi); 42 USC 633.

(4) by adding "or" after the semicolon at the end of clause (vi); and

(5) by inserting after clause (vi) the following new clause:

"(vii) a person who is working not less than 30 hours per week;".

(b) Section 402(a)(19)(B) of such Act is amended by inserting "to families with dependent children" immediately after "that aid". 42 USC 602.

(c) Section 402(a)(19)(D) of such Act is amended by striking out ", and income derived from a special work project under the program established by section 432(b)(3)". 42 USC 632.

(d) Section 402(a)(19)(F) of such Act is amended—

(1) by striking out, "and for so long as any child, relative, or individual (certified to the Secretary of Labor pursuant to subparagraph (G))" in the matter preceding clause (i), and inserting in lieu thereof "(and for such period as is prescribed under joint regulations of the Secretary and the Secretary of Labor) any child, relative or individual"; and

(2) by inserting "and" after the semicolon at the end of clause (iv), and striking out all that follows.

(e) Section 402(a)(19)(G) of such Act is amended—

(1) by inserting "(which will, to the maximum extent feasible, be located in the same facility as that utilized for the administration of programs established pursuant to section 432(b) (1), (2), or (3))" immediately after "administrative unit" in clause (i);

(2) by striking out "subparagraph (A)," in clause (ii), and inserting in lieu thereof "subparagraph (A) of this paragraph (I)";

(3) by striking out "part C" where it first appears in clause (ii) and inserting in lieu thereof "section 432(b) (1), (2), or (3)"; and

(4) by striking out "employment or training under part C," in clause (ii) and inserting in lieu thereof "employment or training under section 432(b) (1), (2), or (3), (II) such social and supportive services as are necessary to enable such individuals as determined appropriate by the Secretary of Labor actively to engage in other employment-related (including but not limited to employment search) activities, as well as timely payment for necessary employment search expenses, and (III) for a period deemed appropriate by the Secretary of Labor after such an individual accepts employment, such social and supportive services as are reasonable and necessary to enable him to retain such employment,".

(f) Section 402(a)(19) of such Act is further amended—

(1) by striking out "and" at the end of subparagraph (F);

(2) by adding "and" after the semicolon at the end of subparagraph (G); and

(3) by adding after subparagraph (G) the following new subparagraph:

"(H) that an individual participating in employment search activities shall not be referred to employment opportunities which do not meet the criteria for appropriate work

and training to which an individual may otherwise be assigned under section 432(b)(1), (2), or (3);".

42 USC 602
42 USC 603

(g) Section 403(c) of such Act is amended by striking out "part C" and inserting in lieu thereof "section 432(b)(1), (2), or (3)".

(h) Section 403(d)(1) of such Act is amended by adding at the end thereof the following new sentence: "In determining the amount of the expenditures made under a State plan for any quarter with respect to social and supportive services pursuant to section 402(a)(19)(G), there shall be included the fair and reasonable value of goods and services furnished in kind from the State or any political subdivision thereof.".

Ante, p. 361

42 USC 602 note

(i) The amendments made by this section (other than those made by subsections (c) and (d)) shall take effect on September 30, 1980, and the joint regulations referred to in section 402(a)(19)(F) of the Social Security Act (as amended by this section) shall be promulgated on or before such date, and take effect on such date.

USE OF INTERNAL REVENUE SERVICE TO COLLECT CHILD SUPPORT FOR NON-AFDC FAMILIES

SEC. 402. (a) The first sentence of section 452(b) of the Social Security Act is amended by inserting "(or undertaken to be collected by such State pursuant to section 454(6))" immediately after "assigned to such State".

42 USC 652
42 USC 654

Effective date
42 USC 652 note

(b) The amendment made by subsection (a) shall take effect July 1, 1980.

SAFEGUARDS RESTRICTING DISCLOSURE OF CERTAIN INFORMATION UNDER AFDC AND SOCIAL SERVICE PROGRAMS

42 USC 602

SEC. 403. (a) Section 402(a)(9) of the Social Security Act is amended—

(1) by striking out "and" at the end of clause (B); and

(2) by striking out "; and the safeguards" and all that follows and inserting in lieu thereof the following: ", and (D) any audit or similar activity conducted in connection with the administration of any such plan or program by any governmental entity which is authorized by law to conduct such audit or activity; and the safeguards so provided shall prohibit disclosure, to any committee or legislative body (other than an entity referred to in clause (D) with respect to an activity referred to in such clause), of any information which identifies by name or address any such applicant or recipient;".

42 USC 1397b

(b) Section 2003(d)(1)(B) of such Act is amended—

(1) by striking out "provides that" and inserting in lieu thereof "provides safeguards which restrict";

(2) by striking out "will be restricted";

(3) by inserting "(A)" after "connected with"; and

(4) by inserting before the semicolon at the end thereof the following: ", and (B) any audit or similar activity conducted in connection with the administration of any such plan or program by any governmental entity which is authorized by law to conduct such audit or activity; and the safeguards so provided shall prohibit disclosure, to any committee or legislative body (other than an entity referred to in clause (B) with respect to an activity referred to in such clause), of any information which identifies by name or address any such applicant or recipient;".

(c) The amendments made by this section shall take effect on September 1, 1980. Effective date. 42 USC 602 note.

FEDERAL MATCHING FOR CHILD SUPPORT DUTIES PERFORMED BY CERTAIN COURT PERSONNEL

SEC. 404. (a) Section 455 of the Social Security Act is amended by adding at the end thereof the following new subsection: 42 USC 655.

"(c)(1) Subject to paragraph (2), there shall be included, in determining amounts expended by a State during any quarter for the operation of the plan approved under section 454, so much of the expenditures of courts of such State and its political subdivisions (excluding expenditures for or in connection with judges and other individuals making judicial determinations, but not excluding expenditures for or in connection with their administrative and support personnel) as are attributable to the performance of services which are directly related to, and clearly identifiable with, the operation of such plan. 42 USC 654.

"(2) The aggregate amount of the expenditures which are included pursuant to paragraph (1) for the quarters in any calendar year shall be reduced (but not below zero) by the total amount of expenditures described in paragraph (1) which were made by the State for the 12-month period beginning January 1, 1978.

"(3) The State agency may, if the law (or procedures established thereunder) of the State so provides, pay so much of the amount it receives under subsection (a) for any quarter as is payable by reason of the provisions of this subsection directly to the courts of the State (or political subdivisions thereof) furnishing the services on account of which the payment is payable.".

(b) The amendment made by subsection (a) shall apply with respect to expenditures made by States on or after July 1, 1980. Effective date. 42 USC 655 note.

CHILD SUPPORT MANAGEMENT INFORMATION SYSTEM

SEC. 405. (a) Section 455(a) of the Social Security Act is amended— 42 USC 655.

(1) by striking out "and" at the end of paragraph (1);

(2) by striking out the period at the end of paragraph (2) and inserting in lieu thereof ", and "; and

(3) by adding after and below paragraph (2) the following new paragraph:

"(3) equal to 90 percent (rather than the percent specified in clause (1) or (2)) of so much of the sums expended during such quarter as are attributable to the planning, design, development, installation or enhancement of an automatic data processing and information retrieval system which the Secretary finds meets the requirements specified in section 454(16);". Automatic data processing and information retrieval system. *Infra.*

(b) Section 454 of such Act is amended— 42 USC 654.

(1) by striking out "and" at the end of paragraph (14),

(2) by striking out the period at the end of paragraph (15) and inserting in lieu thereof "; and", and

(3) by adding after paragraph (15) the following new paragraph:

"(16) provide, at the option of the State, for the establishment, in accordance with an (initial and annually updated) advance automatic data processing planning document approved under section 452(d), of an automatic data processing and information retrieval system designed effectively and efficiently to assist *Post*, p. 464.

management in the administration of the State plan, in the State and localities thereof, so as (A) to control, account for, and monitor (i) all the factors in the child support enforcement collection and paternity determination process under such plan (including, but not limited to, (I) identifiable correlation factors (such as social security numbers, names, dates of birth, home addresses and mailing addresses (including postal ZIP codes) of any individual with respect to whom child support obligations are sought to be established or enforced and with respect to any person to whom such support obligations are owing) to assure sufficient compatibility among the systems of different jurisdictions to permit periodic screening to determine whether such individual is paying or is obligated to pay child support in more than one jurisdiction, (II) checking of records of such individuals on a periodic basis with Federal, intra- and inter-State, and local agencies, (III) maintaining the data necessary to meet the Federal reporting requirements on a timely basis, and (IV) delinquency and enforcement activities), (ii) the collection and distribution of support payments (both intra- and inter-State), the determination, collection and distribution, of incentive payments both inter- and intra-State, and the maintenance of accounts receivable on all amounts owed, collected and distributed, and (iii) the costs of all services rendered, either directly or by interfacing with State financial management and expenditure information, (B) to provide interface with records of the State's aid to families with dependent children program in order to determine if a collection of a support payment causes a change affecting eligibility for or the amount of aid under such program, (C) to provide for security against unauthorized access to, or use of, the data in such system, and (D) to provide management information on all cases under the State plan from initial referral or application through collection and enforcement.".

42 USC 652.

(c) Section 452 of such Act is amended by adding at the end thereof the following new subsection:

"(d)(1) The Secretary shall not approve the initial and annually updated advance automatic data processing planning document, referred to in section 454(16), unless he finds that such document, when implemented, will generally carry out the objectives of the management system referred to in such subsection, and such document—

Ante, p. 463.

"(A) provides for the conduct of, and reflects the results of, requirements analysis studies, which include consideration of the program mission, functions, organization, services, constraints, and current support, of, in, or relating to, such system,

"(B) contains a description of the proposed management system referred to in section 455(a)(3), including a description of information flows, input data, and output reports and uses,

Ante, p. 463.

"(C) sets forth the security and interface requirements to be employed in such management system,

"(D) describes the projected resource requirements for staff and other needs, and the resources available or expected to be available to meet such requirements,

"(E) contains an implementation plan and backup procedures to handle possible failures,

"(F) contains a summary of proposed improvement of such management system in terms of qualitative and quantitative benefits, and

"(G) provides such other information as the Secretary determines under regulation is necessary.

"(2)(A) The Secretary shall through the separate organizational unit established pursuant to subsection (a), on a continuing basis, review, assess, and inspect the planning, design, and operation of, management information systems referred to in section 455(a)(3), *Ante*, p. 463. with a view to determining whether, and to what extent, such systems meet and continue to meet requirements imposed under paragraph (1) and the conditions specified under section 454(16). *Ante*, p. 463.

"(B) If the Secretary finds with respect to any statewide management information system referred to in section 455(a)(3) that there is a failure substantially to comply with criteria. requirements, and other undertakings, prescribed by the advance automatic data processing planning document theretofore approved by the Secretary with respect to such system, then the Secretary shall suspend his approval of such document until there is no longer any such failure of such system to comply with such criteria, requirements, and other undertakings so prescribed.".

(d) Section 452 of the Social Security Act is further amended by adding after subsection (d) (as added by subsection (c) of this section) *Ante*, p. 464. the following new subsection:

"(e) The Secretary shall provide such technical assistance to States as he determines necessary to assist States to plan, design, develop, or install and provide for the security of, the management information systems referred to in section 455(a)(3).". Technical assistance to States.

(e) The amendments made by this section shall take effect on July 1, 1981, and shall be effective only with respect to expenditures, referred to in section 455(a)(3) of the Social Security Act (as amended by this Act), made on or after such date. Effective date. 42 USC 652 note.

AFDC MANAGEMENT INFORMATION SYSTEM

SEC. 406. (a) Section 403(a)(3) of the Social Security Act is amended— 42 USC 603.

(1) by striking out "and" at the end of subparagraph (A);

(2) by redesignating subparagraph (B) as subparagraph (C); and

(3) by inserting after subparagraph (A) the following new subparagraph:

"(B) 90 per centum of so much of the sums expended during such quarter as are attributable to the planning, design, development, or installation of such statewide mechanized claims processing and information retrieval systems as (i) meet the conditions of section 402(a)(30), and *Infra.* (ii) the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of State plans approved under title XIX, and State programs with respect to which there is Federal financial participation under title XX, and". 42 USC 1396. 42 USC 1397.

(b)(1) Section 402(a) of such Act is amended— 42 USC 602.

(A) by striking out "and" at the end of paragraph (28);

(B) by striking out the period at the end of paragraph (29) and inserting in lieu thereof "; and"; and

(C) by adding after paragraph (29) the following new paragraph:

"(30) at the option of the State, provide for the establishment and operation, in accordance with an (initial and annually updated) advance automatic data processing planning document approved under subsection (d), of an automated statewide management information system designed effectively and efficiently, to assist management in the administration of the State plan for aid to families with dependent children approved under this part, so as (A) to control and account for (i) all the factors in the total eligibility determination process under such plan for aid (including but not limited to (I) identifiable correlation factors (such as social security numbers, names, dates of birth, home addresses, and mailing addresses (including postal ZIP codes), of all applicants and recipients of such aid and the relative with whom any child who is such an applicant or recipient is living) to assure sufficient compatibility among the systems of different jurisdictions to permit periodic screening to determine whether an individual is or has been receiving benefits from more than one jurisdiction, (II) checking records of applicants and recipients of such aid on a periodic basis with other agencies, both intra- and inter-State, for determination and verification of eligibility and payment pursuant to requirements imposed by other provisions of this Act), (ii) the costs, quality, and delivery of funds and services furnished to applicants for and recipients of such aid, (B) to notify the appropriate officials of child support, food stamp, social service, and medical assistance programs approved under title XIX whenever the case becomes ineligible or the amount of aid or services is changed, and (C) to provide for security against unauthorized access to, or use of, the data in such system.".

42 USC 1396

42 USC 602

(2) Section 402 of such Act is further amended by adding at the end thereof the following new subsection:

"(d)(1) The Secretary shall not approve the initial and annually updated advance automatic data processing planning document, referred to in subsection (a)(30), unless he finds that such document, when implemented, will generally carry out the objectives of the statewide management system referred to in such subsection, and such document—

Ante, p. 465

"(A) provides for the conduct of, and reflects the results of, requirements analysis studies, which include consideration of the program mission, functions, organization, services, constraints, and current support, of, in, or relating to, such system,

"(B) contains a description of the proposed statewide management system, including a description of information flows, input data, and output reports and uses,

"(C) sets forth the security and interface requirements to be employed in such statewide management system,

"(D) describes the projected resource requirements for staff and other needs, and the resources available or expected to be available to meet such requirements,

"(E) includes cost-benefit analyses of each alternative management system, data processing services and equipment, and a cost allocation plan containing the basis for rates, both direct and indirect, to be in effect under such statewide management system,

"(F) contains an implementation plan with charts of development events, testing descriptions, proposed acceptance criteria, and backup and fallback procedures to handle possible failure of contingencies, and

"(G) contains a summary of proposed improvement of such statewide management system in terms of qualitative and quantitative benefits.

"(2)(A) The Secretary shall, on a continuing basis, review, assess, and inspect the planning, design, and operation of, statewide management information systems referred to in section 403(a)(3)(B), with a view to determining whether, and to what extent, such systems meet and continue to meet requirements imposed under such section and the conditions specified under subsection (a)(30) of this section.

Ante, p. 465.

Ante, p. 466.

"(B) If the Secretary finds with respect to any statewide management information system referred to in section 403(a)(3)(B) that there is a failure substantially to comply with criteria, requirements, and other undertakings, prescribed by the advance automatic data processing planning document theretofore approved by the Secretary with respect to such system, then the Secretary shall suspend his approval of such document until there is no longer any such failure of such system to comply with such criteria, requirements, and other undertakings so prescribed.".

(c) Part A of title IV of such Act is amended by adding at the end thereof the following new section:

"TECHNICAL ASSISTANCE FOR DEVELOPING MANAGEMENT INFORMATION SYSTEMS

"SEC. 413. The Secretary shall provide such technical assistance to States as he determines necessary to assist States to plan, design, develop, or install and provide for the security of, the management information systems referred to in section 403(a)(3)(B) of this Act.".

42 USC 612.

Ante, p. 465.

(d) The amendments made by this section shall be effective with respect to expenditures made during calendar quarters beginning on or after July 1, 1981.

Effective date.
42 USC 612 note.

CHILD SUPPORT REPORTING AND MATCHING PROCEDURES

SEC. 407. (a) Section 455(b)(2) of the Social Security Act is amended by striking out "The Secretary" and inserting in lieu thereof "Subject to subsection (d), the Secretary".

42 USC 655.

(b) Section 455 of such Act is further amended by adding after subsection (c) (as added by section 404 of this Act) the following new subsection:

Ante, p. 463.

"(d) Notwithstanding any other provision of law, no amount shall be paid to any State under this section for any quarter, prior to the close of such quarter, unless for the period consisting of all prior quarters for which payment is authorized to be made to such State under subsection (a), there shall have been submitted by the State to the Secretary, with respect to each quarter in such period (other than the last two quarters in such period), a full and complete report (in such form and manner and containing such information as the Secretary shall prescribe or require) as to the amount of child support collected and disbursed and all expenditures with respect to which payment is authorized under subsection (a).".

(c) Section 403(b)(2) of such Act is amended—

42 USC 603.

(1) by striking out "and" at the end of clause (A); and

(2) by adding immediately before the semicolon at the end of clause (B) the following: ", and (C) reduced by such amount as is necessary to provide the 'appropriate reimbursement of the Federal Government' that the State is required to make under

42 USC 657

section 457 out of that portion of child support collections retained by it pursuant to such section".

Effective date
42 USC 603 note

(d) The amendments made by this section shall be effective in the case of calendar quarters commencing on or after January 1, 1981.

ACCESS TO WAGE INFORMATION FOR PURPOSES OF CARRYING OUT STATE PLANS FOR CHILD SUPPORT

26 USC 6103

SEC. 408. (a)(1) Subsection (l) of section 6103 of the Internal Revenue Code of 1954 (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end thereof the following new paragraph:

"(7) DISCLOSURE OF CERTAIN RETURN INFORMATION BY SOCIAL SECURITY ADMINISTRATION TO STATE AND LOCAL CHILD SUPPORT ENFORCEMENT AGENCIES.—

"(A) IN GENERAL.—Upon written request, the Commissioner of Social Security shall disclose directly to officers and employees of a State or local child support enforcement agency return information from returns with respect to net earnings from self-employment (as defined in section 1402), wages (as defined in section 3121(a) or 3401(a)), and payments of retirement income which have been disclosed to the Social Security Administration as provided by paragraph (1) or (5) of this subsection.

26 USC 1402
26 USC 3121, 3401

"(B) RESTRICTION ON DISCLOSURE.—The Commissioner of Social Security shall disclose return information under subparagraph (A) only for purposes of, and to the extent necessary in, establishing and collecting child support obligations from, and locating, individuals owing such obligations. For purposes of the preceding sentence, the term 'child support obligations' only includes obligations which are being enforced pursuant to a plan described in section 454 of the Social Security Act which has been approved by the Secretary of Health and Human Services under part D of title IV of such Act.

"Child support obligations."

42 USC 654

42 USC 651.

"(C) STATE OR LOCAL CHILD SUPPORT ENFORCEMENT AGENCY.—For purposes of this paragraph, the term 'State or local child support enforcement agency' means any agency of a State or political subdivision thereof operating pursuant to a plan described in subparagraph (B)."

26 USC 6103.

(2)(A) Subparagraph (A) of section 6103(p)(3) of such Code (relating to records of inspection and disclosure) is amended by striking out "(l)(1) or (4)(B) or (5)" and inserting in lieu thereof "(l)(1), (4)(B), (5), or (7)".

(B) Paragraph (4) of section 6103(p) of such Code (relating to safeguards) is amended by striking out "(l)(3) or (6)" in so much of such paragraph as precedes subparagraph (A) thereof and inserting in lieu thereof "(l)(3), (6), or (7)".

(C) Clause (i) of section 6103(p)(4)(F) of such Code is amended by striking out "(l)(6)" and inserting in lieu thereof "(l)(6) or (7)".

(D) The first sentence of paragraph (2) of section 7213(a) of such Code is amended by striking out "subsection (d), (l)(6), or (m)(4)(B)" and inserting in lieu thereof "subsection (d), (l)(6) or (7), or (m)(4)(B)".

26 USC 7213

Effective date
26 USC 6103 note.

(3) The amendments made by this subsection shall take effect on the date of the enactment of this Act.

42 USC 503.

(b)(1) Section 303 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(d)(1) The State agency charged with the administration of the State law—

"(A) shall disclose, upon request and on a reimbursable basis, directly to officers or employees of any State or local child support enforcement agency any wage information contained in the records of such State agency, and Wage information.

"(B) shall establish such safeguards as are necessary (as determined by the Secretary of Labor in regulations) to insure that information disclosed under subparagraph (A) is used only for purposes of establishing and collecting child support obligations from, and locating, individuals owing such obligations. Safeguards, establishment.

For purposes of the preceding sentence, the term 'child support obligations' only includes obligations which are being enforced pursuant to a plan described in section 454 of this Act which has been approved by the Secretary of Health and Human Services under part D of title IV of this Act. "Child support obligations" 42 USC 654. 42 USC 651.

"(2) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State. Noncompliance of State agency.

"(3) For purposes of this subsection, the term 'State or local child support enforcement agency' means any agency of a State or political subdivision thereof operating pursuant to a plan described in the last sentence of paragraph (1)." Definition.

(2) Paragraph (2) of section 304(a) of the Social Security Act is amended by striking out "subsection (b) or (c)" and inserting in lieu thereof "subsection (b), (c), or (d)". 42 USC 504.

(3) The amendments made by this subsection shall take effect on July 1, 1980. Effective date. 42 USC 503 note.

TITLE V—OTHER PROVISIONS RELATING TO THE SOCIAL SECURITY ACT

RELATIONSHIP BETWEEN SOCIAL SECURITY AND SSI BENEFITS

SEC. 501. (a) Part A of title XI of the Social Security Act is amended by inserting immediately after section 1126 the following new section:

"ADJUSTMENT OF RETROACTIVE BENEFITS UNDER TITLE II ON ACCOUNT OF SUPPLEMENTAL SECURITY INCOME BENEFITS

"SEC. 1127. Notwithstanding any other provision of this Act, in any case where an individual— 42 USC 1320a-6.

"(1) makes application for benefits under title II and is subsequently determined to be entitled to those benefits, and

"(2) was an individual with respect to whom supplemental security income benefits were paid under title XVI (including State supplementary payments which were made under an agreement pursuant to section 1616(a) or an administration agreement under section 212 of Public Law 93-66) for one or more months during the period beginning with the first month 42 USC 1381. 87 Stat. 155.

for which a benefit described in paragraph (1) is payable and ending with the month before the first month in which such benefit is paid pursuant to the application referred to in paragraph (1),

the benefits (described in paragraph (1)) which are otherwise retroactively payable to such individual for months in the period described in paragraph (2) shall be reduced by an amount equal to so much of such supplemental security income benefits (including State supplementary payments) described in paragraph (2) for such month or months as would not have been paid with respect to such individual or his eligible spouse if the individual had received the benefits under title II at the times they were regularly due during such period rather than retroactively; and from the amount of such reduction the Secretary shall reimburse the State on behalf of which such supplementary payments were made for the amount (if any) by which such State's expenditures on account of such supplementary payments for the period involved exceeded the expenditures which the State would have made (for such period) if the individual had received the benefits under title II at the times they were regularly due during such period rather than retroactively. An amount equal to the portion of such reduction remaining after reimbursement of the State under the preceding sentence shall be covered into the general fund of the Treasury.".

42 USC 401

42 USC 404

(b) Section 204 of such Act is amended by adding at the end thereof the following new subsection:

"(e) For payments which are adjusted by reason of payment of benefits under the supplemental security income program established by title XVI, see section 1127.".

42 USC 1381 *Ante*, p. 469

42 USC 1383

(c) Section 1631(b) of such Act is amended—

(1) by inserting "(1)" immediately after "(b)", and

(2) by adding at the end thereof the following new paragraph:

"(2) For payments for which adjustments are made by reason of a retroactive payment of benefits under title II, see section 1127.".

42 USC 401 *Ante*, p. 469

42 USC 1320a-6 note

(d) The amendments made by this section shall be applicable in the case of payments of monthly insurance benefits under title II of the Social Security Act entitlement for which is determined on or after the first day of the thirteenth month which begins after the date of the enactment of this Act.

EXTENSION OF NATIONAL COMMISSION ON SOCIAL SECURITY

42 USC 907a

SEC. 502. (a) Section 361(a)(2)(F) of the Social Security Amendments of 1977 is amended by striking out "a term of two years" and inserting in lieu thereof "a term which shall end on April 1, 1981".

(b) Section 361(c)(2) of the Social Security Amendments of 1977 is amended by striking out all that follows the semicolon and inserting in lieu thereof "and the Commission shall cease to exist on April 1, 1981."

TIME FOR MAKING OF SOCIAL SECURITY CONTRIBUTIONS WITH RESPECT TO COVERED STATE AND LOCAL EMPLOYEES

42 USC 418

SEC. 503. (a) Subparagraph (A) of section 218(e)(1) of the Social Security Act is amended to read as follows:

"(A) that the State will pay to the Secretary of the Treasury, within the thirty-day period immediately following the last day of each calendar month, amounts equivalent to the sum of the

taxes which would be imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 if the services for which wages were paid in such month to employees covered by the agreement constituted employment as defined in section 3121 of such Code; and". 26 USC 3101, 3111. 26 USC 3121.

(b) The amendment made by subsection (a) shall be effective with respect to the payment of taxes (referred to in section 218(e)(1)(A) of the Social Security Act, as amended by subsection (a)) on account of wages paid on or after July 1, 1980. Effective date. 42 USC 418 note. 42 USC 418.

(c) The provisions of section 7 of Public Law 94-202 shall not be applicable to any regulation which becomes effective on or after July 1, 1980, and which is designed to carry out the purposes of subsection (a) of this section. 42 USC 405a. 42 USC 405a note.

ELIGIBILITY OF ALIENS FOR SSI BENEFITS

SEC. 504. (a) Section 1614(f) of the Social Security Act is amended by adding at the end thereof the following new paragraph: 42 USC 1382c.

"(3) For purposes of determining eligibility for and the amount of benefits for any individual who is an alien, such individual's income and resources shall be deemed to include the income and resources of his sponsor and such sponsor's spouse (if such alien has a sponsor) as provided in section 1621. Any such income deemed to be income of such individual shall be treated as unearned income of such individual.". *Infra.*

(b) Part A of title XVI of such Act is amended by adding at the end thereof (after the new section added by section 201(c) of this Act) the following new section: *Ante*, p. 445.

"ATTRIBUTION OF SPONSOR'S INCOME AND RESOURCES TO ALIENS

"SEC. 1621. (a) For purposes of determining eligibility for and the amount of benefits under this title for an individual who is an alien, the income and resources of any person who (as a sponsor of such individual's entry into the United States) executed an affidavit of support or similar agreement with respect to such individual, and the income and resources of the sponsor's spouse, shall be deemed to be the income and resources of such individual (in accordance with subsections (b) and (c)) for a period of three years after the individual's entry into the United States. Any such income deemed to be income of such individual shall be treated as unearned income of such individual. Eligibility determination for benefits. 42 USC 1382j.

"(b)(1) The amount of income of a sponsor (and his spouse) which shall be deemed to be the unearned income of an alien for any year shall be determined as follows:

"(A) The total yearly rate of earned and unearned income (as determined under section 1612(a)) of such sponsor and such sponsor's spouse (if such spouse is living with the sponsor) shall be determined for such year. *Ante*, p. 449.

"(B) The amount determined under subparagraph (A) shall be reduced by an amount equal to (i) the maximum amount of the Federal benefit under this title for such year which would be payable to an eligible individual who has no other income and who does not have an eligible spouse (as determined under section 1611(b)(1)), plus (ii) one-half of the amount determined under clause (i) multiplied by the number of individuals who are dependents of such sponsor (or such sponsor's spouse if such 42 USC 1382.

spouse is living with the sponsor), other than such alien and such alien's spouse.

"(C) The amount of income which shall be deemed to be unearned income of such alien shall be at a yearly rate equal to the amount determined under subparagraph (B). The period for determination of such amount shall be the same as the period for determination of benefits under section 1611(c).

42 USC 1382

"(2) The amount of resources of a sponsor (and his spouse) which shall be deemed to be the resources of an alien for any year shall be determined as follows:

42 USC 1382b

"(A) The total amount of the resources (as determined under section 1613) of such sponsor and such sponsor's spouse (if such spouse is living with the sponsor) shall be determined.

"(B) The amount determined under subparagraph (A) shall be reduced by an amount equal to (i) $1,500 in the case of a sponsor who has no spouse with whom he is living, or (ii) $2,250 in the case of a sponsor who has a spouse with whom he is living.

"(C) The resources of such sponsor (and spouse) as determined under subparagraphs (A) and (B) shall be deemed to be resources of such alien in addition to any resources of such alien.

"(c) In determining the amount of income of an alien during the period of three years after such alien's entry into the United States, the reduction in dollar amounts otherwise required under section 1612(a)(2)(A)(i) shall not be applicable if such alien is living in the household of a person who is a sponsor (or such sponsor's spouse) of such alien, and is receiving support and maintenance in kind from such sponsor (or spouse), nor shall support or maintenance furnished in cash or kind to an alien by such alien's sponsor (to the extent that it reflects income or resources which were taken into account in determining the amount of income and resources to be deemed to the alien under subsection (a) or (b)) be considered to be income of such alien under section 1612(a)(2)(A).

42 USC 1382a.

Information and documentation respecting sponsor.

"(d)(1) Any individual who is an alien shall, during the period of three years after entry into the United States, in order to be an eligible individual or eligible spouse for purposes of this title, be required to provide to the Secretary such information and documentation with respect to his sponsor as may be necessary in order for the Secretary to make any determination required under this section, and to obtain any cooperation from such sponsor necessary for any such determination. Such alien shall also be required to provide to the Secretary such information and documentation as the Secretary may request and which such alien or his sponsor provided in support of such alien's immigration application.

"(2) The Secretary shall enter into agreements with the Secretary of State and the Attorney General whereby any information available to such persons and required in order to make any determination under this section will be provided by such persons to the Secretary, and whereby such persons shall inform any sponsor of an alien, at the time such sponsor executes an affidavit of support or similar agreement, of the requirements imposed by this section.

Sponsor and alien, liability for overpayment.

"(e) Any sponsor of an alien, and such alien, shall be jointly and severably liable for an amount equal to any overpayment made to such alien during the period of three years after such alien's entry into the United States, on account of such sponsor's failure to provide correct information under the provisions of this section, except where such sponsor was without fault, or where good cause for such failure existed. Any such overpayment which is not repaid to the Secretary

or recovered in accordance with section 1631(b) shall be withheld from any subsequent payment to which such alien or such sponsor is entitled under any provision of this Act. *Ante*, p. 470.

"(f)(1) The provisions of this section shall not apply with respect to any individual who is an 'aged, blind, or disabled individual' for purposes of this title by reason of blindness (as determined under section 1614(a)(2)) or disability (as determined under section 1614(a)(3)), from and after the onset of the impairment, if such blindness or disability commenced after the date of such individual's admission into the United States for permanent residence. "Aged, blind, or disabled individual", nonapplicability. 42 USC 1382c.

"(2) The provisions of this section shall not apply with respect to any alien who is—

"(A) admitted to the United States as a result of the application, prior to April 1, 1980, of the provisions of section 203(a)(7) of the Immigration and Nationality Act; 8 USC 1153.

"(B) admitted to the United States as a result of the application, after March 31, 1980, of the provisions of section 207(c)(1) of such Act; *Ante*, p. 103.

"(C) paroled into the United States as a refugee under section 212(d)(5) of such Act; or *Ante*, p. 107.

"(D) granted political asylum by the Attorney General.".

(c) The amendments made by this section shall be effective with respect to individuals applying for supplemental security income benefits under title XVI of the Social Security Act for the first time after September 30, 1980. Effective date. 42 USC 1382j note. 42 USC 1381.

AUTHORITY FOR DEMONSTRATION PROJECTS

SEC. 505. (a)(1) The Secretary of Health and Human Services shall develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of (A) various alternative methods of treating the work activity of disabled beneficiaries under the old-age, survivors, and disability insurance program, including such methods as a reduction in benefits based on earnings, designed to encourage the return to work of disabled beneficiaries and (B) altering other limitations and conditions applicable to such disabled beneficiaries (including, but not limited to, lengthening the trial work period, altering the 24-month waiting period for medicare benefits, altering the manner in which such program is administered, earlier referral of beneficiaries for rehabilitation, and greater use of employers and others to develop, perform, and otherwise stimulate new forms of rehabilitation), to the end that savings will accrue to the Trust Funds, or to otherwise promote the objectives or facilitate the administration of title II of the Social Security Act. 42 USC 1310 note. 42 USC 401.

(2) The experiments and demonstration projects developed under paragraph (1) shall be of sufficient scope and shall be carried out on a wide enough scale to permit a thorough evaluation of the alternative methods under consideration while giving assurance that the results derived from the experiments and projects will obtain generally in the operation of the disability insurance program without committing such program to the adoption of any particular system either locally or nationally.

(3) In the case of any experiment or demonstration project under paragraph (1), the Secretary may waive compliance with the benefit requirements of titles II and XVIII of the Social Security Act insofar as is necessary for a thorough evaluation of the alternative methods 42 USC 401, 1395.

under consideration. No such experiment or project shall be actually placed in operation unless at least ninety days prior thereto a written report, prepared for purposes of notification and information only and containing a full and complete description thereof, has been transmitted by the Secretary to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate. Periodic reports on the progress of such experiments and demonstration projects shall be submitted by the Secretary to such committees. When appropriate, such reports shall include detailed recommendations for changes in administration or law, or both, to carry out the objectives stated in paragraph (1).

Report to Congress.

(4) The Secretary shall submit to the Congress no later than January 1, 1983, a report on the experiments and demonstration projects with respect to work incentives carried out under this subsection together with any related data and materials which he may consider appropriate.

42 USC 401.

(5) Section 201 of the Social Security Act is amended by adding at the end thereof (after the new subsection added by section 310(a) of this Act) the following new subsection:

Ante, p. 459.

"(k) Expenditures made for experiments and demonstration projects under section 505(a) of the Social Security Disability Amendments of 1980 shall be made from the Federal Disability Insurance Trust Fund and the Federal Old-Age and Survivors Insurance Trust Fund, as determined appropriate by the Secretary.".

Ante, p. 473.

42 USC 1310.

(b) Section 1110 of the Social Security Act is amended—

(1) by inserting "(1)" after "SEC. 1110. (a)";

(2) by striking out "for (1)" and "(2)" and inserting in lieu thereof "for (A)" and "(B)", respectively;

(3) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively;

(4) by striking out "under subsection (a)" each place it appears and inserting in lieu thereof "under paragraph (1)";

(5) by striking out "purposes of this section" and inserting in lieu thereof "purposes of this subsection"; and

(6) by adding at the end thereof the following new subsection:

Waiver.
42 USC 1381.

"(b)(1) The Secretary is authorized to waive any of the requirements, conditions, or limitations of title XVI (or to waive them only for specified purposes, or to impose additional requirements, conditions, or limitations) to such extent and for such period as he finds necessary to carry out one or more experimental, pilot, or demonstration projects which, in his judgment, are likely to assist in promoting the objectives or facilitate the administration of such title. Any costs for benefits under or administration of any such project (including planning for the project and the review and evaluation of the project and its results), in excess of those that would have been incurred without regard to the project, shall be met by the Secretary from amounts available to him for this purpose from appropriations made to carry out such title. The costs of any such project which is carried out in coordination with one or more related projects under other titles of this Act shall be allocated among the appropriations available for such projects and any Trust Funds involved, in a manner determined by the Secretary, taking into consideration the programs (or types of benefit) to which the project (or part of a project) is most closely related or which the project (or part of a project) is intended to benefit. If, in order to carry out a project under this subsection, the Secretary requests a State to make supplementary payments (or makes them himself pursuant to an agreement under section 1616),

42 USC 1382e.

or to provide medical assistance under its plan approved under title XIX, to individuals who are not eligible therefor, or in amounts or under circumstances in which the State does not make such payments or provide such medical assistance, the Secretary shall reimburse such State for the non-Federal share of such payments or assistance from amounts appropriated to carry out title XVI. 42 USC 1396. 42 USC 1381.

"(2) With respect to the participation of recipients of supplemental security income benefits in experimental, pilot, or demonstration projects under this subsection—

"(A) the Secretary is not authorized to carry out any project that would result in a substantial reduction in any individual's total income and resources as a result of his or her participation in the project;

"(B) the Secretary may not require any individual to participate in a project; and he shall assure (i) that the voluntary participation of individuals in any project is obtained through informed written consent which satisfies the requirements for informed consent established by the Secretary for use in any experimental, pilot, or demonstration project in which human subjects are at risk, and (ii) that any individual's voluntary agreement to participate in any project may be revoked by such individual at any time;

"(C) the Secretary shall, to the extent feasible and appropriate, include recipients who are under age 18 as well as adult recipients; and

"(D) the Secretary shall include in the projects carried out under this section such experimental, pilot, or demonstration projects as may be necessary to ascertain the feasibility of treating alcoholics and drug addicts to prevent the onset of irreversible medical conditions which may result in permanent disability, including programs in residential care treatment centers.".

(c) The Secretary shall submit to the Congress a final report with respect to all experiments and demonstration projects carried out under this section no later than five years after the date of the enactment of this Act. Report to Congress. 42 USC 1310 note.

ADDITIONAL FUNDS FOR DEMONSTRATION PROJECT RELATING TO THE TERMINALLY ILL

SEC. 506. (a) The Secretary of Health and Human Services is authorized to provide for the participation, by the Social Security Administration, in a demonstration project relating to the terminally ill which is currently being conducted within the Department of Health and Human Services. The purpose of such participation shall be to study the impact on the terminally ill of provisions of the disability programs administered by the Social Security Administration and to determine how best to provide services needed by persons who are terminally ill through programs over which the Social Security Administration has administrative responsibility. 42 USC 1395ll note.

(b) For the purpose of carrying out this section there are authorized to be appropriated such sums (not in excess of $2,000,000 for any fiscal year) as may be necessary. Appropriation authorization.

VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 507. (a) Title XVIII of the Social Security Act is amended by adding at the end thereof the following new section:

"VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

42 USC 1395ss

"SEC. 1882. (a) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)(1)) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c). Such certification shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement.

Emblem.

Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

List of certified policies.

State regulatory program, standards and requirements.

"(b)(1) Any medicare supplemental policy issued in any State which the Supplemental Health Insurance Panel (established under paragraph (2)) determines has established under State law a regulatory program that—

"(A) provides for the application of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A));

"(B) includes a requirement equal to or more stringent than the requirement described in subsection (c)(2); and

"(C) provides for application of the standards and requirements described in subparagraphs (A) and (B) to all medicare supplemental policies (as defined in subsection (g)(1)) issued in such State,

shall be deemed (for so long as the Panel finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c).

Supplemental Health Insurance Panel, establishment.

"(2)(A) There is hereby established a panel (hereinafter in this section referred to as the 'Panel') to be known as the Supplemental Health Insurance Panel. The Panel shall consist of the Secretary, who shall serve as the Chairman, and four State commissioners or superintendents of insurance, who shall be appointed by the President and serve at his pleasure. Such members shall first be appointed not later than December 31, 1980.

Quorum

"(B) A majority of the members of the Panel shall constitute a quorum, but a lesser number may conduct hearings.

"(C) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Panel may require.

"(D) There are authorized to be appropriated such sums as may be necessary to carry out this paragraph. Appropriation authorization.

"(E) Members of the Panel shall be allowed, while away from their homes or regular places of business in the performance of services for the Panel, travel expenses (including per diem in lieu of subsistence) in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5, United States Code. Travel expenses.

"(c) The Secretary shall certify under this section any medicare supplemental policy, or continue certification of such a policy, only if he finds that such policy— Medicare supplemental policy, certification criteria.

"(1) meets or exceeds (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another) the NAIC Model Standards; and

"(2) can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 60 percent of the aggregate amount of premiums collected in the case of individual policies.

For purposes of paragraph (2), policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies. Individual policies.

"(d)(1) Whoever knowingly or willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards and requirements set forth in subsection (c) or in regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed by the Secretary under subsection (a), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both. False statement or representation, penalties and fines.

"(2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting, under the authority of or in association with, the program of health insurance established by this title, or any Federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both.

"(3)(A) Whoever knowingly sells a health insurance policy to an individual entitled to benefits under part A or enrolled under part B of this title, with knowledge that such policy substantially duplicates health benefits to which such individual is otherwise entitled, other than benefits to which he is entitled under a requirement of State or Federal law (other than this title), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both. 42 USC 1395c, 1395j.

"(B) For purposes of this paragraph, benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual, shall not be considered as duplicative.

"(C) Subparagraph (A) shall not apply with respect to the selling of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations.

Policies mailed for prohibited purpose.

"(4)(A) Whoever knowingly, directly or through his agent, mails or causes to be mailed any matter for a prohibited purpose (as determined under subparagraph (B)) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both.

Definition.

"(B) For purposes of subparagraph (A), a prohibited purpose means the advertising, solicitation, or offer for sale of a medicare supplemental policy, or the delivery of such a policy, in or into any State in which such policy has not been approved by the State commissioner or superintendent of insurance. For purposes of this paragraph, a medicare supplemental policy shall be deemed to be approved by the commissioner or superintendent of insurance of a State if—

"(i) the policy has been certified by the Secretary pursuant to subsection (c) or was issued in a State with an approved regulatory program (as defined in subsection (g)(2)(B));

"(ii) the policy has been approved by the commissioners or superintendents of insurance in States in which more than 30 percent of such policies are sold; or

"(iii) the State has in effect a law which the commissioner or superintendent of insurance of the State has determined gives him the authority to review, and to approve, or effectively bar from sale in the State, such policy;

except that such a policy shall not be deemed to be approved by a State commissioner or superintendent of insurance if the State notifies the Secretary that such policy has been submitted for approval to the State and has been specifically disapproved by such State after providing appropriate notice and opportunity for hearing pursuant to the procedures (if any) of the State.

Exceptions.

"(C) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a medicare supplemental policy into a State if such person has ascertained that the party insured under such policy to whom (or on whose behalf) such policy is mailed is located in such State on a temporary basis.

"(D) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a duplicate copy of a medicare supplemental policy previously issued to the party to whom (or on whose behalf) such duplicate copy is mailed, if such policy expires not more than 12 months after the date on which the duplicate copy is mailed.

Benefit information.

"(e) The Secretary shall provide to all individuals entitled to benefits under this title (and, to the extent feasible, to individuals about to become so entitled) such information as will permit such individuals to evaluate the value of medicare supplemental policies to them and the relationship of any such policies to benefits provided under this title.

State regulatory programs, study and evaluation.

"(f)(1)(A) The Secretary shall, in consultation with Federal and State regulatory agencies, the National Association of Insurance Commissioners, private insurers, and organizations representing

consumers and the aged, conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of medicare supplemental policies in (i) limiting marketing and agent abuse, (ii) assuring the dissemination of such information to individuals entitled to benefits under this title (and to other consumers) as is necessary to permit informed choice, (iii) promoting policies which provide reasonable economic benefits for such individuals, (iv) reducing the purchase of unnecessary duplicative coverage, (v) improving price competition, and (vi) establishing effective approved State regulatory programs described in subsection (b).

"(B) Such study shall also address the need for standards or certification of health insurance policies, other than medicare supplemental policies, sold to individuals eligible for benefits under this title.

"(C) The Secretary shall, no later than January 1, 1982, submit a report to the Congress on the results of such study and evaluation, accompanied by such recommendations as the Secretary finds warranted by such results with respect to the need for legislative or administrative changes to accomplish the objectives set forth in subparagraphs (A) and (B), including the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of medicare supplemental policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies. Report to Congress.

"(2) The Secretary shall submit to the Congress no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less often than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section, and shall include in such reports an analysis of— Report to Congress.

"(A) the impact of such procedure and penalties on the types, market share, value, and cost to individuals entitled to benefits under this title of medicare supplemental policies which have been certified by the Secretary;

"(B) the need for any change in the certification procedure to improve its administration or effectiveness; and

"(C) whether the certification program and criminal penalties should be continued.

"(g)(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations. For purposes of this section, the term 'policy' includes a certificate issued under such policy. Medicare supplemental policy, definition. "Policy."

"(2) For purposes of this section:

"(A) The term 'NAIC Model Standards' means the 'NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act', adopted by the "NAIC Model Standards."

National Association of Insurance Commissioners on June 6, 1979, as it applies to medicare supplement policies.

Definition

"(B) The term 'State with an approved regulatory program' means a State for which the Panel has made a determination under subsection (b)(1).

"(C) The State in which a policy is issued means—

"(i) in the case of an individual policy, the State in which the policyholder resides; and

"(ii) in the case of a group policy, the State in which the holder of the master policy resides.

Regulations

"(h) The Secretary shall prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the certification procedure established under this section. The Secretary shall first issue final regulations to implement the certification procedure established under subsection (a) not later than March 1, 1981.

Emblem usage, effective date

"(i)(1) No medicare supplemental policy shall be certified and no such policy may be issued bearing the emblem authorized by the Secretary under subsection (a) until July 1, 1982. On and after such date policies certified by the Secretary may bear such emblem, including policies which were issued prior to such date and were subsequently certified, and insurers may notify holders of such certified policies issued prior to such date using such emolem in the notification.

"(2)(A) The Secretary shall not implement the certification program established under subsection (a) with respect to policies issued in a State unless the Panel makes a finding that such State cannot be expected to have established, by July 1, 1982, an approved State regulatory program meeting the standards and requirements of subsection (b)(1). If the Panel makes such a finding, the Secretary shall implement such program under subsection (a) with respect to medicare supplemental policies issued in such State, until such time as the Panel determines that such State has a program that meets the standards and requirements of subsection (b)(1).

Panel findings, transmittal to congressional committees; effective date

"(B) Any finding by the Panel under subparagraph (A) shall be transmitted in writing, not later than January 1, 1982, to the Committee on Finance of the Senate and to the Committee on Interstate and Foreign Commerce and the Committee on Ways and Means of the House of Representatives and shall not become effective until 60 days after the date of its transmittal to the Committees of the Congress under this subparagraph. In counting such days, days on which either House is not in session because of an adjournment sine die or an adjournment of more than three days to a day certain are excluded in the computation.

"(j) Nothing in this section shall be construed so as to affect the right of any State to regulate medicare supplemental policies which, under the provisions of this section, are considered to be issued in another State.".

(b) The amendment made by this section shall become effective on the date of the enactment of this Act, except that the provisions of paragraph (4) of section 1882(d) of the Social Security Act (as added by this section) shall become effective on July 1, 1982.

Effective date.
42 USC 1395ss note.

Ante, p. 476.

Approved June 9, 1980.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 96-109 (Comm. on Ways and Means) and No. 96-944 (Comm. of Conference).
SENATE REPORT No. 96-408 (Comm. on Finance).
CONGRESSIONAL RECORD:
Vol. 125 (1979): Sept. 6, considered and passed House.
Dec. 5, considered in Senate.
Vol. 126 (1980): Jan. 30, 31, considered and passed Senate, amended.
May 22, House agreed to conference report.
May 29, Senate agreed to conference report.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS:
Vol. 16, No. 24 (1980): June 9, Presidential statement.

○

96th Congress, 1st Session - - - - - - - - - - House Report No. 96-100

DISABILITY INSURANCE AMENDMENTS OF 1979

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

together with

ADDITIONAL AND SUPPLEMENTAL VIEWS

TO ACCOMPANY

H.R. 3236

TO PROVIDE BETTER WORK INCENTIVES AND IMPROVED ACCOUNTABILITY IN THE DISABILITY INSURANCE PROGRAM

APRIL 23, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 96-100

DISABILITY INSURANCE AMENDMENTS OF 1979

Apr. 23, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

together with

ADDITIONAL AND SUPPLEMENTAL VIEWS

[To accompany H.R. 3236]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3236) to amend title II of the Social Security Act to provide better work incentives and improved accountability in the disability insurance program, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 2, line 14, after "subsection" insert "other than paragraphs (3)(A), (3)(C), and (5)".

Page 3, after line 18, insert the following new paragraph:

> (4) Section 215(i)(2)(D) of such Act is amended by adding at the end thereof the following new sentence: "Notwithstanding the preceding sentence, such revision of maximum family benefits shall be subject to paragraph (6) of section 203(a) (as added by section 2(a)(3) of the Disability Insurance Amendments of 1979).".

Page 4, line 10, strike out "or who has died".

Page 4, line 11, insert "or who has died," after "subparagraph),".

Page 4, line 20, strike out "death or".

Page 4, lines 22 and 23, strike out "he dies, attains such age, or" and insert in lieu thereof "he attains such age or".

Page 9, line 15, strike out the comma.

Page 18, line 10, strike out "30 percent" and insert in lieu thereof "15 percent".

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Page 18, line 12, strike out "60 percent" and insert in lieu thereof "35 percent".

Page 18, line 14, strike out "80 percent" and insert in lieu thereof "65 percent".

Page 20, after line 8, insert the following new subsection:

> (h) The Secretary of Health, Education, and Welfare shall submit to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate by January 1, 1980, a detailed plan on how he expects to assume the functions and operations of a State disability determination unit when this becomes necessary under the amendments made by this section. Such plan should assume the uninterrupted operation of the disability determination function and the utilization of the best qualified personnel to carry out such function. If any amendment of Federal law or regulation is required to carry out such plan, recommendations for such amendment should be included in the plan for action by such committees, or for submittal by such committees with appropriate recommendations to the committees having jurisdiction over the Federal civil service and retirement laws.

Page 20, strike out the sentence beginning on line 18.

I. Summary of Principal Provisions

The bill (H.R. 3236), as amended by your committee, would (a) curb excessive benefits that in some instances may exceed the predisability earnings on which the benefits are based, (b) provide more incentives for disabled people to return to work, (c) improve accountability in the disability insurance program, and (d) make other important changes in the disability program.

LIMITATION ON TOTAL FAMILY BENEFITS

In the case of disabled workers who become entitled to a disability insurance benefit in the future, a limit would be established on the maximum amount of total benefits that may be paid to workers and their dependents. The limit would be 80 percent of a worker's average indexed monthly earnings (AIME) or 150 percent of primary insurance amount (PIA), whichever is lower (but with a minimum guarantee of 100 percent of the PIA).

VARIABLE DROP-OUT YEARS FOR YOUNGER DISABLED WORKERS

The number of years of low or no earnings that can be dropped in computing a disabled worker's benefits who becomes entitled in the future would vary by the age of the worker, according to the following schedule:

Worker's age:	*Number of dropout years*
Under 27	0
27 through 31	1
32 through 36	2
37 through 41	3
42 through 46	4
47 and over	5

The provision would also credit 1 dropout year for each year in which the worker provides principal care of a child under age 6. In no case could the number of dropout years exceed 5.

WORK INCENTIVES

To stimulate more disabled beneficiaries to return to work despite their impairments, your committee's bill would:

(*a*) Provide that the same trial work period applicable to disabled workers would be provided to disabled widow(er)s;

(*b*) Deduct extraordinary impairment-related work expenses, attendant care costs, and the cost of medical devices and equipment from his earnings for purposes of determining if a disabled person were engaging in substantial gainful activity (SGA);

(*c*) Extend the present 9-month trial work period to 24 months. In the last 15 months of the 24-month period, the individual would not receive benefits if he earned over the SGA amount, but would retain his eligibility for benefits if he finds he must return to the the disability rolls.

(*d*) Extend Medicare coverage for an additional 36 months to disabled beneficiaries who return to substantial gainful work; and

(*e*) Eliminate the second 24-month Medicare waiting period where a person again becomes disabled and entitled to benefits.

DISABILITY DETERMINATIONS AND REVIEW OF STATE AGENCY ALLOWANCES

Authority would be granted to the Secretary to establish, through regulations, procedures and performance standards for the States to follow in the disability determination process. States would be given the option of (1) continuing to administer the program in compliance with these regulations, or (2) turning over administration to the Federal Government.

Also, the Secretary would be required to review State agency determinations before the payment of benefits and must review the following percentages of allowances: at least 15 percent in fiscal year 1980; at least 35 percent in fiscal year 1981; and at least 65 percent in fiscal year 1982 and thereafter.

REHABILITATION EXPENDITURES

Your committee's bill replaces the current Beneficiary Rehabilitation Program with a program of disability trust fund reimbursements for vocational rehabilitations which meet performance standards based on return to the labor market. A State could receive twice the State's share of the cost of rehabilitation services if those services result in the disabled beneficiary engaging in substantial gainful activity or employment in a sheltered workshop for 12 continuous months. Also, monthly benefits would continue to be paid to people who have medically recovered if they are still in an approved vocational rehabilitation program, if the Social Security Administration determines that continuing in such a program will increase the probability of the person going off the benefit rolls permanently.

PERIODIC REVIEW OF DISABILITY DETERMINATIONS

Each beneficiary on the rolls, unless a finding has been made that his disability is permanent, would be reviewed at least once every 3 years.

PAYMENT FOR EXISTING MEDICAL EVIDENCE

The social security trust funds would reimburse non-Federal institutions and physicians for medical evidence of record that they submitted to support claims for disability benefits.

DETAILED DECISION NOTICES

Notices to claimants for benefits would provide a brief statement of the pertinent law and regulations, a concise summary of the evidence and reason for the decision.

PAYMENT FOR CERTAIN TRAVEL EXPENSES

The social security trust funds would pay for reasonable costs of travel for claimants to obtain required medical examinations, and for claimants and their witnesses and representatives to reconsideration interviews and hearings. Previously, these amounts have been authorized under annual appropriations acts.

II. Purposes and Scope: General Discussion

A. WORK INCENTIVES

Family Benefit Limit (section 2).—Recent actuarial studies in both the public and private sector have indicated that high replacement rates (the ratio of benefits to previous earnings) have constituted a major disincentive to disabled people in attempting rehabilitation or generally returning to the work force. A recent analysis by the Social Security Administration actuaries has indicated:

> The average replacement ratio of newly entitled disabled workers with median earnings and who have qualifying dependents increased from about 60 percent in 1967 to over 90 percent in 1976, an increase of about 50 percent. During this time the gross recovery rate decreased to only one-half of what it was in 1967. High benefits are a formidable incentive to maintain beneficiary status especially when the value of medicare and other benefits are considered. We believe that the incentive to return to permanent self-supporting work provided by the trial work period provision has been largely negated by the prospect of losing the high benefits. ("Experience of Disabled-Workers Benefits Under OASDI, 1972–76," actuarial study No. 75, June 1978.)

John H. Miller, probably the most knowledgeable disability actuary in the private sector, points to the role of high replacement rates in recent adverse social security disability experience:

> The evidence is clear that liberal disability benefits induce both an increase in the number of cases approved and the prolongation of disability. From a social and humanistic

point of view, we are presented with a dilemma, namely, how we can provide adequate benefits to those unfortunate individuals who become and remain truly disabled, without removing or greatly reducing the incentive to overcome the disability.

Secretary Califano testified before the Social Security Subcommittee in February of this year:

> Benefits in approximately 6 percent of all cases actually exceed the disabled person's previous net earnings; and approximately 16 percent of beneficiaries receive benefits that are more than 80 percent of their average predisability net earnings.

The primary mechanism in your committee's bill to provide replacement rates which better support incentives to work is the limitation on family benefits. When it is combined with the other work incentive aspects of the bill it is hoped that beneficiary motivation will be more positive towards vocational rehabilitation and return to the labor market.

A number of elements underlie the philosophy of the committee's limitation:

(1) It is designed primarily to strengthen work incentives for disabled beneficiaries.

(2) It is temporary and a transition in the sense that when the social security benefit structure and formula are examined later in this Congress in a comprehensive way, other approaches might be found preferable for the long term, such as a separate disability benefit formula, a revised family maximum for all or individual programs (disability, retirement, survivors), non-wage-related dependents' benefits, or taxing disability benefits.

(3) Although it assumes that a few more families would have to supplement their benefits through AFDC than do families under social security disability at the present time, the proposal is not designed to take "welfare" out of social security.

Section 2 of the committee bill would limit total DI family benefits to an amount equal to the smaller of 80 percent of a worker's average indexed monthly earnings (AIME) or 150 percent of the worker's primary benefit (PIA). The AIME limitation is designed to affect wage earners at lower earnings levels while the 150 percent of PIA limitation will generally affect average and high wage earners. No family benefit would be reduced below 100 percent of the worker's primary benefit. The limitation would be effective only for entitlements on or after January 1, 1980, based on disabilities that began after calendar year 1978.

In determining a reasonable limit on benefits for disabled-worker families, the committee gave consideration to the experience of private insurers. Private insurers generally limit benefits to no more than two-thirds of predisability gross earnings to avoid providing benefits so high that people are as well of, or better off, financially after they begin receiving the disability payments than when they were working. Your committee decided that the limit under social security should exceed that of private insurers because of it is the primary benefit base for the American worker and often is the only source of income for

families of workers who have the lowest earnings. Your committee believes that, on balance, 80 percent of AIME would provide a reasonable ceiling on family benefits.

For workers at higher wage levels, social security benefits should replace less than 80 percent of AIME. At higher wage levels, concern for benefit adequacy is less, the likelihood of private supplementation is greater, and the discrepancy between gross earnings (upon which social security benefits are based) and predisability disposable earnings is greater than in the case of the lower paid worker. In recognition of these factors, your committee has adopted a provision which also limits family benefit to 150 percent of the worker's primary insurance amount. This provision will produce family benefits that are less than 80 percent of AIME for the families affected, with the percentage declining to about 50 percent of AIME at the highest earnings levels.

Social security benefits are based on gross earnings, not earnings net of Federal and State taxes and work-related expenses. Because such taxes and expenses vary widely depending on the worker's residence, the size of the worker's family, and the nature of the work, any approximation in terms of gross earnings will have different effects in individual situations. However, calculations using various hypothetical cases suggest that the combination of 80 percent of AIME and 150 percent of PIA, whichever is lower, produces what seems to be a reasonable wage replacement pattern at various earnings levels, a reasonable return for the higher paid worker, and a reasonable relationship between pre- and post-disability disposable income. Any more stringent limitation would necessarily affect many beneficiaries who do not have other major sources of income, and whose benefits may already be relatively low.

The limit on benefits would affect only 30 percent of newly entitled disabled workers. Seventy percent of people coming on the rolls do not have eligible dependents and, thus, would not be affected by a cap on family benefits. It is estimated that 123,000 disabled-worker families would be affected by the cap in the first year.

A number of other interrelated provisions in the Committee bill are designed to eliminate work disincentives.

Reduced Dropout Years (section 3).—To reduce the disparity in disability benefits between young and older disabled workers, section 3 of the bill would vary the number of dropout years by age for disability entitlements after 1979. Workers of all ages are allowed to exclude 5 years of low earnings in the averaging period for benefit purposes. For a worker age 50 or over this exclusion reprresents only 18 percent of his or her earnings history (5 years out of 28). It represents, however, a 71 percent exclusion for a 29-year-old (5 years out of 7). Under your committee bill, there would be no dropout years allowed for workers under age 27 and the number of dropped years would gradually rise to 5 dropout years (as under existing law) for workers age 47 and over. However, if a worker provided principal care for a child under age 6 for more than 6 months in any calendar year that was a year of low earnings, that year could also be dropped up to a combined total of 5 dropout years. This latter provision would not be effective until January, 1981. During the year before this provision is due to take effect, the Social Security Administration should

study the administrative feasibility of the provision and make a report to the Committee on Ways and Means on how the provision would be implemented, with recommendations for any necessary changes in the statute. This report should be submitted no later than January 1, 1980.

Substantial Gainful Activity (SGA) (sections 4 and 5).—A number of witnesses testifying before the Subcommittee on Social Security recommended substantial increases in the amount of monthly earnings which determines the ability to engage in substantial gainful activity. SGA is an integral part of the definition of disability which governs not only whether an individual is terminated from the rolls because he has demonstrated the ability to return to work, but also determines the basic eligibility for severely impaired persons who are not on the rolls but are working to a substantial degree. The result of any major change in the concept of SGA is not verifiable by any substantial body of knowledge. Thus, authority to waive benefit requirements of title II and title XVIII would be authorized under section 4 so that demonstration projects could be carried out to ascertain alternative methods of treating work activity to stimulate a return to gainful employment by disability beneficiaries. It is not the intent of your committee that participants in such projects would be disadvantaged in contrast to existing law. Research findings in this area are urgently needed for enlightened policy determinations in dealing with SGA and related problems.

To further stimulate work efforts for severely disabled individuals, section 5 of your committee's bill would permit deduction of extraordinary impairment-related work expenses, attendant care costs, and the cost of medical devices, equipment, and drugs and services (necessary control an impairment) from a disabled beneficiary's earnings for purposes of determining if he engaged in substantial gainful activity. Examples of drugs and services necessary to control an impairment would be the anti-convulsant drugs and services to control epilepsy, anti-convulsant blood level monitoring, EEG and brain scan, etc. This provision would reduce the disincentive to work of many disabled beneficiaries who are motivated to work but have high impairment-related work and other expenses.

Trial Work and Medicare Extension (sections 6 and 7).—The provisions on trial work and the amendments to medicare which complement them were included in the subcommittee's bill of last session and adopted by the administration in its recommendation this session. Moreover, the Advisory Council on Social Security which will report in the fall has fully supported the trial work amendments in its tentative recommendations submitted to the subcommittee and full committee for consideration in the disability insurance legislation.

Section 6 of your committee bill in effect extends the present 9-month trial work period to 24 months. In the last 12 months of the 24-month period, the individual would not receive cash benefits unless he finds he must return to the disability rolls.

Your committee thinks the present 9-month trial work period is insufficient as an incentive for disabled people to return to work, and wants this situation corrected. This change would preclude people who work for some time and then, because of their impairment, must stop work, from having to refile an application and having to go through

the lengthy disability determination process again. This change would not only help the disabled claimants but it would also reduce the Social Security Administration's workload.

Section 6 of the bill also provides that the same trial work period will be applicable to disabled widow(er)s. One purpose of the trial work period is to provide the opportunity for a disabled person to test his/her ability to work. It would be desirable to provide disabled widow(er)s with the same incentives to return to work as are provided to other disabled beneficiaries.

Section 6 of the bill also extends medicare coverage for an additional 36 months over existing law to disabled beneficiaries who, though not medically recovered, have returned to substantial gainful work. Under present law, people who may be able to work despite their impairment often do not try to work because of the fear of losing their monthly cash benefits and medicare coverage. They are particularly concerned they will be unable to get any public or private medical care coverage. Thus, this provision removes the potential loss of medicare coverage as a deterrent to work effort for this substantial period.

Section 7 of the bill eliminates the requirement that a person who becomes disabled again must serve another 24-month waiting period before medicare coverage is available to him. This amendment would apply to workers becoming disabled again within 60 months, and to disabled widow(er)s and adults disabled since childhood becoming disabled again within 84 months. This would remove the present-law requirement that frequently discourages a disabled beneficiary from returning to productive employment. Also, where a disabled person was initially on the cash benefit rolls but not for 24 months and did not receive medicare coverage, the time spent in cash benefit status would count for purposes of receiving medicare coverage if a subsequent disability occurred within a certain period of time.

B. PROGRAM ACCOUNTABILITY AND UNIFORMITY OF ADMINISTRATION (SECTIONS 8 AND 17)

In the last several years, GAO and others have criticized the lack of uniformity and the quality of disability decisions made by the various State agencies. It must be recognized that, while the Federal-State determination system generally works reasonably well (many State agencies do an excellent job), significant improvements in Federal management and control over State performance are necessary to ensure uniform treatment of all claimants and to improve the quality of decisionmaking under the Nation's largest Federal disability program.

Your committee's bill, therefore, is intended to strengthen the Federal role in the Federal-State system by increasing direct Federal management control over how disability determinations are made in the State agencies and by requiring increased Federal review of State determinations. It should also be emphasized that program accountability is not solely a problem of State administration and that it is equally important that accountability be maintained in Federal administration of the disability insurance program. It is the hope of your committee that such accountability has not been impaired by

the recent "functional" reorganizations of the Social Security Administration.

In order to strengthen Federal management of the system, section 8 of the bill would eliminate the current system of negotiated agreements between the Federal Government and the States, which give the Secretary of Health, Education, and Welfare only general authority over the program, and which leave great discretion to the States as to how the disability determination process is to be carried out. The bill would give the Secretary the authority to establish through regulations the procedures and performance standards for the State disability determination programs. The regulations might specify, for example, administrative structure, the physical location of and relationship among agency staff units, performance criteria, fiscal control procedures, and other rules applicable to State agencies and designed to assure equity and uniformity in State agency disability determinations.

States would have the option of administering the program in compliance with these standards or turning over administration to the Federal Government. States that decide to administer the program must comply with standards set by the Secretary subject to termination by the Secretary if the State substantially fails to comply with the regulations and written guidelines. Your committee believes that this new Federal administrative authority will both improve the quality of determinations and ensure that claimants throughout the Nation will be judged under the same uniform standards and procedures, while preserving the basic Federal-State structure.

If a State elects not to continue administration or the Secretary terminates a State's administration because of substantial failure to comply with regulations, it is essential that there be adequate procedures to establish Federal administration. Two issues are of particular concern: the position of the State employees involved, and the potential disruption of the ongoing determination process which could create hardships for disability applicants.

Under your committee's bill there is more likelihood that some States may decide not to participate under the program or that the Secretary may determine that a State is not complying with the regulatory requirements promulgated under this legislation. Although your committee does not expect any widespread departure from traditional State administration of the disability determination process, it is prudent to anticipate that this may happen in a few jurisdictions. Even though under existing law States have the power to terminate agreements (in fact, the State of Wisconsin filed and then withdrew a termination notice last year), the Department of HEW appears not to have done any extensive planning for Federal administration of State agencies.

Thus, to stimulate Department planning as to such a contingency and to inform the Congress as to what problems would be presented and possible means of alleviating them, your committee's bill would require the Secretary to submit to the Congress, no later than January 1, 1980, a detailed plan on how he expects to assume the functions and operations of a State disability determination unit should it become necessary. The bill further states that such a plan should assume the uninterrupted operation of the disability determination proc-

ess, including the utilization of the best qualified personnel to carry out this function.

Your Committee also recommends that the Department of HEW give consideration to establishing conditions of employment so that the most qualified State employees would not be substantially disadvantaged in transferring to Federal employment. The bill states, in this regard, that recommendations for any amendments of Federal law or regulations required to carry out the plan should be submitted with the plan to the House Ways and Means and the Senate Finance Committees who may then submit them with appropriate recommendations to the committees having jurisdiction over the Federal civil service and retirement laws (the House Post Office and Civil Service Committee, and the Senate Committee on Governmental Affairs).

As to the Federal review of the State agency decisions, your committee is concerned that within the past decade the Social Security Administration moved from what had been a preadjudicative review of the majority of State agency decisions to a sample postadjudicative review involving only 5 percent of such cases. Your committee is aware that varied elements contributed to the Social Security Administration's decision to make these administrative changes. Among these were the demands of the 1972 black lung amendments and a reduction in positions for budget purposes.

Your committee's bill returns to substantially the situation existing prior to 1972 as to the review of allowances. The requirement in section 8 of the bill for increased Federal review on a preadjudicative basis is phased-in over a 3-year period, beginning in 1980, so that there can be an orderly increase in trained staff necessary to carry out this purpose. This review is set at 15 percent in fiscal year 1980, 35 percent in 1981, and 65 percent in 1982 and thereafter. Your committee recognizes, however, that in some instances reviewing this percentage of cases may not be cost-effective—a lower or higher percentage may be prudent. If the Secretary finds this to be the case, we would expect him to report his findings to your committee in an expeditious manner.

Your committee is also concerned by the lack of followup on the medical condition and the possible work activity of individuals who have been on the rolls for years. Section 17 of the bill provides, therefore, that unless the adjudicator in the State agency makes a finding that the individual is under a disability which is permanent, there will be a review of the status of disabled beneficiaries at least once every 3 years. Your committee's bill emphasizes that all existing reviews of eligibility under the law are to be continued and expanded where necessary.

Your committee understands that the Social Security Administration already schedules a review in about 20 percent of new disability cases (where there is a reasonable expectation that a disabled beneficiary will show medical improvement). In order to give SSA enough time to hire and train additional staff to conduct the reviews required by this section, your committee believes that the provision should apply to all new determinations of disability after the date of enactment and that reviews and scheduling of necessary medical examinations for all current disability cases be completed no later than 3 years after the date of enactment.

If periodic review at least every 3 years proves not to be cost-effective, the Secretary should report this to the committee.

C. REHABILITATION EXPENDITURES AND PROGRAM EFFECTIVENESS (SECTIONS 13 AND 14)

In recent years the cost effectiveness of the provisions which authorize vocational rehabilitation (VR) expenditures out of the disability trust fund have been questioned. Under existing law, an amount equal to 1.5 percent of disability insurance expenditures is potentially available for vocational rehabilitation expenditures. This is called the beneficiary rehabilitation program (BRP).

In June of 1974, the Department reported a savings of $2.50 for every $1 spent. However, in 1976 the GAO reported that previous estimates of benefit savings because of rehabilitation services were not being realized. The GAO study states that the best estimate for a benefit-cost ratio is 1.15. That is, for every $1 of rehabilitation expenditure, $1.15 in trust fund savings is realized. A recent Rutgers University study also arrived at a figure of similar magnitude. The GAO suggested that the administration should freeze funding of the program. This has been done for the last couple of years, although some increase in funding has been made available for increases in the cost of living.

The committee bill contains a provision aimed at providing a more permanent solution to the problem. In terms of simplification and better administration, section 13 of the bill would consolidate the VR funding sources for the seriously disabled in the regular VR program. Your committee realizes that administrative changes will be needed to accommodate this provision. Such changes might include extended tracking of rehabilitated beneficiaries to assess eligibility for reimbursement and the establishment of an appeals procedure to resolve reimbursement disputes. The approach in the committee bill also seems appropriate inasmuch as the Congress, following recommendations of the VR administrators, may place the regular VR program in a new Department of Education.

Section 13 of the bill also replaces the BRP with bonus Federal maching of State regular VR expenditures for those individuals where rehabilitation results in employment at substantial gainful activity (SGA) earning levels for a continuous 12-month period. Such reimbursement would cover costs of services in individual cases, administrative expenses, and counseling and placement costs. The 12-month employment period may begin while the beneficiary is receiving services under a State vocational rehabilitation program and such 12-month period may also coincide with the trial work period. The Congress encourages the advance of trust funds under this provision in such a way as to facilitate financial planning by the Federal and State agencies administering the program.

It is the intent of the committee that funds paid to the States under this provision be utilized by State VR agencies for the rehabilitation of additional SSDI beneficiaries reimbursable under this provision. Under the committee bill, the effective date is fiscal year 1981 to provide for an orderly transition and for adjustment of the authorization of appropriation for the regular VR program which is within the jurisdiction of the Education and Labor Committee. This is very important if the level of support for VR services to SSDI beneficiaries is to be maintained.

The committee bill recognizes that some persons on the disability rolls will only be able to work in sheltered workshop situations at a wage rate below the SGA level. Under this bill there would also be bonus matching for the rehabilitation expenses, but it would be subject to a requirement that they receive wages for the 12-month period after the "rehabilitation" phase of their sheltered workshop experience has been concluded.

Section 14 of the committee bill also provides that no beneficiary be terminated due to medical recovery if the beneficiary is participating in an approved VR program which the Social Security Administration determines will increase the likelihood that the beneficiary may be permanently removed from the disability rolls.

D. CLAIMS AND APPEALS PROCEDURES

The committee bill provides a number of provisions which make the disability adjudication and appeals process more effective and equitable:

Decision Notices.—Section 9, although phrased broadly so as to apply decisions under all title II programs, is designed primarily to improve the social security disability denial notice. Complaints about the denial notices have been voiced for a long time. In fact, the Harrison subcommittee stated in its 1960 report that "the so-called 'denial letter' sent to every disallowed applicant, is merely a form letter which is not individualized to any degree with respect to the particulars of the given case, and gives little, if any, of the reasons for the denial contained in the written determinations of the State agency (p. 28)." Little appears to have changed over the years other than that the denial notice is now generated by a computer.

Your committee believes that the decision notice should contain a clear explanation of the decision, a brief summary of the evidence on which the decision is based, and a brief statement of the law and regulations, if appropriate. This will add a number of positive factors to the adjudication process. The State agency decision will be on a sounder base because the examiner will be required to formulate the reasons for his decision in written form and the claimant may be less likely to appeal the decision if he understands how the law relates to his particular case. This provision will require additional staff resources and may increase processing time at the State agency level.

It is not the intent of your committee that the denial notification be a voluminous document (no more than 2 pages should usually suffice) or, in the case of allowances, that the decision be as detailed as denials. The statement of the case should not include matters the disclosure of which (as indicated by the source of the information involved) would be harmful to the claimant, but if there is any such matter the claimant should be informed of its existence, and it may be disclosed to the claimant's representative unless the latter's relationship with the claimant is such that disclosure would be as harmful as if made to the claimant.

Nondisclosure is to be used sparingly and should not be used in a way which denies to claimants the ability to know the reason for this decision. Full disclosure should be made to an appropriate representative.

Medical Evidence.—Section 15 of the bill would authorize the Secretary to pay all non-Federal providers for costs of supplying medical evidence of record in social security disability claims as is done for SSI disability claims.

Travel Expenses.—Section 16 of the bill would place in permanent law authority for payment of claimant's travel expenses resulting from participation in various phases of the adjudication process.

Court Remands.—Section 11 remedies two chronic problems in the provisions in the law which authorize the remand of court cases back to the administrative process. First, your committee's bill would limit the absolute authority of the Secretary of Health, Education, and Welfare to remand cases back to the appeals council before answer. The Harrison subcommittee suggested in its report that such absolute discretion gave the Secretary the ability to remand cases back so that they could be strengthened to sustain court scrutiny. Other critics, including the Center for Administrative Justice in its 1977 report, believed that the current provision might lead to laxity in appeals council review in that they may get another look at the case if it was appealed to the district court. Your committee's bill would require that such remands would be discretionary with the court upon a showing by the Secretary of good cause.

The second provision relates to remands by the courts. Under existing law the court itself, usually on motion of the claimant, has discretionary authority "for good cause" to remand the cases back to the appeals council and ultimately the administrative law judge. Statistics show that of the 3,205 social security cases disposed of in fiscal 1977, there were 1,257 reversals—about 40 percent. However, only 249 of these cases were reversed directly by the court while 1,008 were reversed after being remanded to the appeals council. Undoubtedly many of these court remands are justified because of the insufficiencies of the prior proceedings. However, it appears that some of the remands are made because the judge disagrees with the outcome of the case which he might have to sustain under the "substantial evidence rule".

Your committee's amendment would require that a remand would be authorized only on a showing that there is new evidence which is material, and that there was good cause for failure to incorporate it into the record in a prior proceeding. The Center for Administrative Justice in its report pointed out that such a provision is contained "in nearly all comparable review statutes". This language is not to be construed as a limitation of judicial remands currently recognized under the law in cases which the Secretary has failed to provide a full and fair hearing, to make explicit findings, or to have correctly apply the law and regulations.

Closed Record.—Section 10 would limit the prospective effect of applications (the so-called floating application) and allow for a more orderly administrative process and closing of the record. Present law provides that if an applicant satisfies the requirements for benefits at any time before a final decision of the Secretary is made, the application is deemed to be filed in the first month for which the requirements are met. One consequence of this provision is that the claimant is afforded a continuing opportunity to establish eligibility until all levels of administrative review have been exhausted, i.e., until there is a

final decision. Thus, a claimant can continue to introduce new evidence at each step of the appeals process, even if it refers to the worsening of a condition or to a new condition that did not exist at the time of the initial application.

The amendment made by this section would allow the issuance of regulations to foreclose the introduction of new evidence with respect to a previously filed application after the decision is made at the administrative ALJ hearing, but would not affect remand authority to remedy an insufficiently documented case or other defect.

Time Limits.—Section 12 of the bill also requires the Secretary of HEW to submit a report to Congress no later than January 1, 1980, recommending appropriate time limits for the various levels of adjudication. Several Federal district courts have imposed such limits at the hearing level and numerous bills have been introduced to set such limits at various levels of adjudication.

The bill requires the Secretary in recommending the limits to give adequate consideration to both speed and quality of adjudication. This would force the administration in program and budget planning to take a harder look at these sometimes conflicting objectives. Congress could then evaluate the recommendations for consistency with the elements it wishes to emphasize and take further action next year.

III. Actuarial Costs and Savings Estimates Under the Bill

Short Term.—The status of the Disability Insurance Trust Fund has greatly improved since the 1977 amendments. Before these amendments it was estimated that the fund would be exhausted by early 1979. The Social Security Amendments of 1977 allocated additional funds to assure its solvency well into the 21st century. The latest trustee's report (1979), which has just been released, shows that by the end of fiscal 1979 the disability trust fund will total over $5.5 billion and that it will grow rapidly during the following 4 fiscal years. At the end of fiscal 1983, it will have a balance of almost $22 billion, which is about 100 percent of estimated benefit expenditure in the following fiscal year. The effect of your committee's bill on the disability trust fund is shown in table A. Table C shows the cost and savings on a provision-by-provision basis. These reflect the estimates of the Social Security Administration actuaries. The estimate of the Congressional Budget Office which appears in section V shows slightly greater savings to the disability trust funds, and includes estimates of H.R. 3236's effect on general revenue funded income maintenance programs.

The improved condition of the fund is due not only to increased financing allocated to the disability program by the 1977 amendments but also to significant improved experience in the program. The fact that the effect of this experience is substantial is shown by table B, which compares estimated experience at the time of the 1977 amendments with actual and estimated experience in the just-released 1979 trustees report. On the other hand, in the near term the Old-Age and Survivors Insurance Trust Fund is expected to decline—due almost entirely to greater than estimated inflation—which about offsets the favorable disability experience. The OASI Trust Fund declines by over $6 billion in the next 3 fiscal years, with the fund totaling only

REDUCTION IN NUMBER OF DROPOUT YEARS FOR YOUNGER DISABLED WORKERS

Section 3(a) of the bill amends section 215(b)(2)(A) of the Social Security Act (as in effect after December 1978) to reduce the number of years that can be dropped from a worker's benefit computation years for a worker who becomes disabled before reaching age 47.

1. The revised clause (i) of section 215(b)(2)(A) provides that the number of years that can be dropped in the case of survivor's benefits will continue to be 5 as under present law; this is also true for old-age cases unless the worker was entitled to a disability benefit for the month before he reached age 65.

2. The new clause (ii) provides that the number of years that can be dropped in a disability case cannot exceed one-fifth of the individual's elapsed years—years after 1951 or age 21; if later, and up to the year of onset of disability. Any resulting fraction of a year will be disregarded.

The limit on the number of dropout years will continue to apply in determining the worker's primary insurance amount in the event of the worker's subsequent disability, or when he reaches age 65, unless he is not entitled to disability insurance benefits for at least 12 months before he becomes eligible again for disability benefits or reaches age 65.

Section 215(b)(2)(A) is also revised to provide for additional dropout years for certain people affected by the reduction in dropout years described above. Under this provision, where regular dropout years are limited to less than 5 by reason of clause (ii), 1 year not otherwise dropped could be dropped for each year in which the worker is responsible for providing, and provides, the principal care of his or her child (or the spouse's child) under the age of 6 for at least 6 full months. (The total number of regular and child care dropout years cannot exceed 5.)

As under present law, section 215(b)(2)(A) provides that the number of an individual's benefit computation years shall be no less than 2.

Section 3(b) of the bill amends section 223(a)(2) of the act to add a reference to new section 215(b)(2)(A)(ii).

Section 3(c) of the bill provides that the amendments made by sections 3(a) and 3(b) of the act, except for the amendment providing for child-care dropout years, would apply with respect to initial entitlements to disability benefits beginning on or after January 1, 1980. The amendment made by section 3(a) dealing with child-care dropout years would be effective for monthly benefits payable for months after 1980.

WORK INCENTIVE—SUBSTANTIAL GAINFUL ACTIVITY DEMONSTRATION PROJECT

Section 4(a) of the bill directs the Commissioner of Social Security to develop and carry out experiments and demonstration projects to determine the relative advantages and disadvantages of alternative methods of treating work activity of social security disability beneficiaries including a reduction in benefits based on earnings, with the objective of encouraging disabled beneficiaries to return to work.

Section 4(b) provides that these projects be of sufficient scope to permit a thorough evaluation of the alternative methods under consideration without committing the disability insurance program to the adoption of any prospective system under consideration.

Section 4(c) provides that the Secretary may waive compliance with the benefit requirements of titles II and XVIII to the extent necessary to effectively carry out such projects; however, no such experiment or project can be implemented until 90 days after notification by the Commissioner of Social Security to the House Committee on Ways and Means and the Senate Committee on Finance. Periodic reports on the progress of such experiments or demonstration projects, including recommendations for changes in law or administration, shall be submitted to the committees.

Section 4(d) specifies that the Commissioner of Social Security shall submit to the Congress, no later than January 1, 1983, a final report on the experiments and demonstration projects, including appropriate related data and materials.

Section 4(e) adds to section 201 of the Social Security Act a new subsection (j) to provide that expenditures made for experiments and demonstration projects will be made from the Federal disability insurance and Federal old-age and survivors trust funds.

EXTRAORDINARY WORK EXPENSES DUE TO SEVERE DISABILITY

Section 5 of the bill amends section 223(d)(4) of the Social Security Act to provide that, where an individual's disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, an amount equal to the cost to him of necessary attendant care services, medical devices, equipment, or prostheses, and similar items and services (not including routine drugs and routine medical care and services unless such drugs are necessary for the control of the disabling condition), whether or not such assistance is also needed for his normal daily functions, shall be excluded from his earnings in determining whether he is able to engage in substantial gainful activity by reason of his earnings.

PROVISION OF TRIAL WORK PERIOD FOR DISABLED WIDOWS; EXTENSION OF ENTITLEMENT TO DISABILITY INSURANCE BENEFITS AND RELATED BENEFITS

Section 6(a) of the bill amends sections 222(c) (1) and (3) of the act to provide a trial work period to disabled widows and widowers in the same manner as provided for disabled workers. These amendments shall apply to those whose disability has not ceased prior to enactment.

Section 6(b)(1) of the bill amends sections 223(a)(1), 202(d)(1)(G), 202(e)(1), and 202(f)(1) of the Social Security Act to extend an individual's status as a disabled individual for 15 months after the completion of a 9-month trial work period, as long as he has not medically recovered Subsection (b)(2) adds a new subsection (e) to section 223 to provide that no benefits would be payable during the last 12 months of this period as long as the individual is engaging in substantial gainful activity. The effect of this amendment will be to allow an individual to return to benefit status without going through the process of reestablishing the fact that he is disabled. Subsection (b)(3) extends medicare coverage for beneficiaries who have completed a

period of trial work, but who have not medically recovered, through the benefit suspension period provided in subsections (b)(1) and (b)(2) and for 24 months afterward, or, if earlier, until the person medically recovers. Subsection (b)(4) provides that these amendments apply to those individuals whose disability has not been determined to have ceased prior to enactment.

ELIMINATION OF REQUIREMENT THAT MONTHS IN MEDICARE WAITING PERIOD BE CONSECUTIVE

Section 7(a) amends sections 226(b), 1811, and 1837(g)(1) of the Social Security Act, and section 7(d)(2)(ii) of the Railroad Retirement Act of 1974 by striking out the word "consecutive" wherever it appears, thereby modifying the medicare 24-month waiting period requirement so that these months need not be consecutive.

Section 7(b) further amends section 226 by adding a new subsection, which provides that, for an individual who is reentitled to the same type of monthly disability benefits, the 24-month waiting period may not include any month in a previous period of disability, if (1) the individual is reentitled as a disabled worker and the previous period of disability terminated more than 60 months before reentitlement; or (2) the individual is reentitled as an adult disabled since childhood, or as a disabled widow or widower, and the previous period of disability terminated more than 84 months before reentitlement.

Section 7(c) provides that these amendments apply to medicare protection for months after the month of enactment.

DISABILITY DETERMINATION; FEDERAL REVIEW OF STATE AGENCY ALLOWANCES

Section 8(a) of the bill amends section 221(a) of the Social Security Act to provide that disability determinations shall be made by State agencies in States that provide a written notice (rather than State agreements, as under present law) to the Secretary stating that they wish to make such determinations, unless the State has previously been found to have substantially failed to make determinations in accordance with the law and the Secretary's regulations, or unless the State has previously declined to administer under this section, in which case the Secretary may determine when and if the State may again make disability determinations. Section 8(a) further provides that disability determinations shall be made (or not made for specified classes of claimants) in accordance with regulations or other written guidelines issued by the Secretary. The Secretary is required to promulgate regulations specifying performance standards and administrative procedures to assure effective and uniform administration, and may issue regulations on State agency administrative structure, and other administrative areas (examples are given in the bill, pp. 15–16).

Section 8(b) of the bill amends section 221(b) of the Social Security Act to provide for notice to a State and opportunity for a hearing if the Secretary determines that the State is substantially failing to make determinations in a manner consistent with the regulations and other written guildelines. If the Secretary makes such a determination, he thereafter will take over the making of the disability determinations

in that State not earlier than the expiration of 180 days. If the State no longer wishes to participate in the program it must notify the Secretary but shall continue to make determinations for not less than 180 days after notification.

Section 8(c) of the bill amends section 221(c) of the Social Security Act to provide (1) that the Secretary shall (rather than "may on his own motion") review State agency determinations that a person is under a disability; (2) that such review shall be made before a determination is implemented and benefits are paid; and (3) that the requirement that the Secretary review such determinations (per(1) above) will be met if he reviews at least 15 percent in fiscal year 1980. 35 percent in fiscal year 1981, and 65 percent in fiscal year 1982 and thereafter.

Sections 8(d), (e) and (f) make conforming changes in the statutory language.

Section 8(g) provides that the amendments made by this section shall be effective 12 months after the month of enactment. Any State that has an agreement with the Secretary already in effect on the effective date will be deemed to have given the notice of participation specified in these amendments. Thereafter, States must give 180 days notice of desire to cease making disability determinations.

Section 8(h) of the bill requires that the Secretary submit to the Ways and Means Committee and Senate Finance Committee by January 1, 1980 a detailed plan on how the Department expects to assume the functions of a State disability determination unit should this become necessary under amendments made by section 8(b). The bill provides that the plan should assume uninterrupted and qualified operation of the function and include any amendments to federal law required to carry out such a plan.

INFORMATION TO ACCOMPANY SECRETARY'S DECISIONS AS TO CLAIMANT'S RIGHTS

Section 9(a) of the bill amends section 205(b) of the Social Security Act to require that any decision by the Secretary shall contain a statement of the case setting forth (1) a list of the pertinent law and regulations, (2) a list and summary of the evidence of record, and (3) the Secretary's determination and the reason(s) upon which it is based.

Section 9(b) provides that this amendment will be effective with respect to decisions made on and after the first day of the second month following the month of enactment.

LIMITATION OF PROSPECTIVE EFFECT OF APPLICATION

Section 10 would amend section 202(j)(2) of the Social Security Act (with parallel amendments to sections 216(i)(2)(G) and 223(b)) to shorten the prospective effect of an application for benefits under title II. In present law, section 202(j)(2) provides that if an applicant satisfies the requirements for benefits at any time before a final decision of the Secretary is made, the application is deemed to be filed in the first month for which the requirements are met. The amendment made by this section would allow the issuance of regulations to foreclose the introduction of new evidence with respect to a previously

filed application after the decision is made at the administrative hearing, but would not affect administrative or judicial remand authority to remedy an insufficiently documented case or other defect. The amendments made by this section shall apply to applications filed after the month in which this Act is enacted.

LIMITATION ON COURT REMANDS

Section 11 of the bill amends section 205(g) of the Social Security Act to provide that the court may, on motion of the Secretary made for good cause shown, remand a case to the Secretary for further action, and that the court may order new and material evidence to be taken before the Secretary if there was good cause for such evidence not having been submitted previously.

TIME LIMITATIONS FOR DECISIONS ON BENEFIT CLAIMS

Section 12 of the bill provides that the Secretary shall submit to the Congress, no later than January 1, 1980, a report recommending the establishment of time limits on decisions on benefit claims. This report shall specifically recommend the maximum periods of time within which (*a*) initial, (*b*) reconsideration, (*c*) hearing, and (*d*) appeals council decisions should be made, taking into consideration both the need for expeditious processing of claims and the need for thorough consideration and accurate determinations of such claims.

VOCATIONAL REHABILITATION SERVICES FOR DISABLED INDIVIDUALS

Section 13 of the bill amends section 222(d) of the Social Security Act to change the provisions authorizing reimbursement from the social security trust funds for the costs of rehabilitation services provided disabled individuals entitled to benefits on the basis of disability.

Section 13(a) of the bill substitutes a revised section 222(d) of the Social Security Act. Paragraph (1) of the revised section 222(d) authorizes the transfer of sums from the trust funds to enable the Secretary to reimburse the general fund of the U.S. Treasury for the Federal share and the State for twice the State share of the reasonable and necessary costs of vocational rehabilitation services furnished under a State plan approved under title I of the Rehabilitation Act of 1973 to disabled individuals entitle to benefits on the basis of disability which results in performance of substantial gainful activity for a continuous period of 12 months, or which results in their employment for a continuous period of 12 months in a sheltered workshop. The Commissioner of Social Security will establish criteria to determine: (1) When the vocational rehabilitation service contributed to successful return to SGA or employment in sheltered workshops and (2) the amount of the costs to be reimbursed. (Under present law, the Secretary is authorized to pay the costs of vocational rehabilitation services for such disabled beneficiaries but the total amount available for this purpose may not exceed 1.5 percent of the total cash benefits paid to disabled workers, disabled widows, disabled widowers, and disabled adult children in the preceding fiscal year.)

The existing paragraph (2) of section 222(d) (relating to requirements for State plans providing rehabilitation services) is eliminated from the revised section.

The existing paragraph (3) of section 222(d) (relating to agreements between the Secretary and public or private agencies for rehabilitation services in States which do not have a plan) is eliminated from the revised section.

The existing paragraph (4) of section 222(b) (relating to arrangements for making payments under this section) is redesignated as paragraph (2) and is amended to provide that payments from the trust funds shall be made in advance (rather than "may be made in installments and in advance") or by way of reimbursement, with necessary adjustments for overpayments and underpayment.

The existing paragraph (5) of section 222(d) (relating to the Secretary's authority to establish methods and procedures for determining the total amount to be reimbursed for the cost of the services, and the amounts to be charged to the individual trust funds) is redesignated as paragraph (3) without any substantive change.

The existing paragraph (6) of section 222(d) (relating to the meaning of the term "vocational rehabilitation services") is redesignated as paragraph (4) and is amended to state that the term "vocational rehabilitation services" would have the meaning assigned to it in title I of the Rehabilitation Act of 1973 (rather than "in the Vocational Rehabilitation Act"), except that such services may be limited in type, scope, or amount in accordance with regulations designed by the Secretary to achieve the purpose of this subsection.

Section 13(a) of the bill also adds a new paragraph (5) to section 222(d) of the Social Security Act to authorize and direct the Secretary to study alternative methods of providing and financing the costs of vocational rehabilitation services to disabled beneficiaries in order to realize maximum savings to the trust funds, and, on or before January 1, 1980, to transmit a report to the President and the Congress containing findings, conclusions, and any recommendations.

Section 13(b) of the bill provides that the amendment made by subsection (a) would apply with respect to fiscal years beginning after September 30, 1980.

CONTINUED PAYMENT OF BENEFITS TO INDIVIDUALS UNDER VOCATIONAL REHABILITATION PLANS

Section 14 of the bill adds to section 225 of the Social Security Act a new subsection (b) to provide that benefits based on disability will not be terminated or suspended because the physical or mental impairment on which such entitlement is based has (or may have) ceased if such beneficiary is participating in an approved vocational rehabilitation program, and the Commissioner of Social Security determines that the completion of such program (or its continuation for a specified period of time) will increase the likelihood that the beneficiary may be permanently removed from the benefit rolls.

PAYMENT FOR EXISTING MEDICAL EVIDENCE

Section 15(a) of the bill amends section 223(d)(5) of the Social Security Act to provide that any non-Federal hospital, clinic, labora-

tory, or other provider of medical services, or physician not in the employ of the Federal Government, which supplies medical evidence required by the Secretary for making determinations of disability, shall be entitled to payment from the Secretary for the reasonable cost of providing such evidence.

Section 15(b) provides that the amendment made by subsection (a) shall apply with respect to evidence supplied on or after the date of the enactment of the act.

PAYMENT OF CERTAIN TRAVEL EXPENSES

Section 16 of the bill adds to section 201 a new subsection (k) to the Social Security Act to authorize payments from the trust funds, to individuals to cover travel expenses incident to medical examinations requested by the Secretary in connection with disability determinations under section 221, and to applicants, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in secion 210(i)) to attend reconsideration interviews and proceedings before administrative law judges under title II of the Social Security Act. The new subsection (k) would provide that payments for air travel shall not exceed coach fare, unless first class accommodations are required due to the health condition of the individual or the unavailability of alternative accommodations. Payments for other means of travel could not exceed the most economical and expeditious arrangements appropriate to such person's health.

PERIODIC REVIEW OF DISABILITY DETERMINATIONS

Section 17 of the bill amends section 221 of the Social Security Act by adding a requirement that, unless a finding has been made that an individual's disability is permanent, the case will be reviewed by either the State agency or the Secretary, for purposes of continuing eligibility, at least once every 3 years. Reviews of cases under the provision shall not be considered as an addition to, and shall not be considered a substitute for, any other reviews of cases in the administration of the disability program.

V. Other Matters To Be Discussed Under the Rules of the House

1. In compliance with clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the vote by your committee on the motion to report the bill, as amended. The motion to report the bill was adopted by a voice vote.

2. In compliance with clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, the following statement is made relative to oversight findings by your committee.

For the last 5 years the full committee and, since its establishment, the Subcommittee on Social Security, have conducted extensive oversight activities on the disability insurance program. These activities are reflected in almost every section of the bill reported by your committee. The following are a few examples.

REPLACEMENT RATE

In late 1975 the subcommittee hired John H. Miller, probably the foremost disability insurance actuary in the country, to study the then deteriorating actuarial condition of the system. Mr. Miller pointed to growing replacement rates as a major contributing factor to this adverse experience. Robert J. Myers, former Chief Actuary of the Social Security Administration, also emphasized this point in the actuarial studies he prepared for the subcommittee in 1975 and 1978. Our "decoupling" legislation in 1977 and section 2 (family benefit limitation) and section 3 (drop-out years) in your committee bill have the effect of substantially reducing replacement rates so that they are neither so much of an incentive to apply for benefits nor a disincentive for beneficiaries to leave the rolls.

NEEDED RESEARCH

Through its oversight activities, your committee found that little in the way of pertinent research material is available in the general area of work incentives for disabled workers. Research findings as to the effect of raising the amount of money that constitutes substantial gainful activity, trial work periods and alternative methods of treating work activity of disabled workers are urgently needed for enlightened policy determinations. Section 4 authorizes experiments and demonstrations in these areas and the waiver of the disability insurance and medicare law where appropriate.

PROGRAM ACCOUNTABILITY

As a result of extensive staff investigation and studies by the General Accounting Office in 1976 and 1978, your committee has found significant weaknesses in the existing Federal/State arrangement and believes that a strengthening of the adjudicative structure and increased Federal supervision and control of State decision making is necessary. Section 8 carries out this objective by authorizing the Secretary of Health, Education, and Welfare to establish a more cohesive and responsive system by regulation.

In addition, your committee has followed closely a significant administrative change in the disability program made in 1972 that was tantamount to an amendment to the statutory scheme of the program. The change from a broad preadjudicative to a very narrow postadjudicative sample review of state agency disability decisions has contributed, in the view of the actuaries, to higher disability incidence rates. Due in part to the Subcommittee on Social Security's oversight of the quality assurance system, recently there has been an improvement in the actuarial condition of the disability program. Section 8 which calls for a return of Federal preadjudicative review and section 17 which requires periodic re-examination of beneficiaries on the rolls will enhance quality of decisionmaking.

REHABILITATION

As to work incentives and rehabilitation, the committee directed the GAO in 1975 to study the trust fund beneficiary rehabilitation pro-

gram. It reported a declining cost-benefit savings ratio for the rehabilitation program and suggested an administrative freeze pending action by the executive and legislative branches which would emphasize the goal of rehabilitations which result in benefit terminations. Section 13, which authorizes trust fund participation only on the basis of the beneficiary's demonstrated return to the labor market evolved from these studies and the subcommittee staff's own oversight activities in this area. The GAO study also suggested numerous changes in the work incentive aspects of the law, some of which are included in your committee's bill; i.e., the extension of medicare coverage after benefit termination (section 6) and elimination of the second waiting period (section 7).

COURT REMAND

Weaknesses in the court remand procedure have been pointed out in earlier oversight studies (the Harrison subcommittee) and more recently, by the Center for Administrative Justice, whose study was recommended by the Ways and Means and Senate Finance Committees. Section 11 limits discretion for both the Secretary of HEW and the courts in their ability to make remands back to the administrative level.

3. In compliance with clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, your committee states that no oversight findings or recommendations have been submitted to your committee by the Committee on Government Operations with respect to the subject matter contained in the bill.

4. In compliance with clause 7 of rule XIII of the Rules of the House of Representatives, the following statement is made relative to the costs incurred in carrying out this bill. A complete discussion of the costs of the social security program provisions of the bill is contained in section III of this report, which describes the financing and operations of the program as amended.

5. In compliance with clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee estimates that the enactment of H.R. 3236 will not have a significant inflationary impact on the national economy.

6. Your committee's cost estimates relating to the provisions of the bill, relating to the Old-Age, Survivors and Disability Insurance program and the Hospital Insurance programs, which were furnished to the committee by the Department of Health, Education, and Welfare, constitute the best information available at this time. Estimates of the bill's impact on general revenue expenditures are set forth in the materials supplied by the Congressional Budget Office, which follow.

7. In compliance with clause 2(l)(3)(B) of rule XI of the Rules of the House of Representatives, your committee advises that H.R. 3236, as reported by your committee, involves no new or increased tax expenditures, and the new budget authority involved therein is tabulated in the report of the Congressional Budget Office, below.

8. In compliance with clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives, the cost estimate supplied your committee by the Congressional Budget Office follows:

CONGRESSIONAL BUDGET OFFICE,
U.S. CONGRESS,
Washington, D.C., April 19, 1979.

Hon. AL ULLMAN,
Chairman, Committee on Ways and Means,
U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to Sections 308(a) and 403 of the Congressional Budget Act, the Congressional Budget Office has prepared the attached cost estimate for H.R. 3236, a bill to amend title II of the Social Security Act to provide better work incentives and improved accountability in the disability insurance program, and for other purposes.

Should the committee so desire, we would be pleased to provide further details on this estimate.

Sincerely,

ALICE M. RIVLIN,
Director.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: H.R. 3236.

2. Bill title: To amend Title II of the Social Security Act to provide better work incentives and improved accountability in the disability insurance (DI) program, and for other purposes.

3. Bill status: As ordered reported by the Committee on Ways and Means on April 9, 1979.

4. Bill purpose: The primary purposes of this bill are (1) to limit benefits to new disability recipients with families and to younger disabled workers; (2) to provide certain work incentives with the objective of increasing the recovery rate of disabled workers; (3) to codify and strengthen certain administrative practices.

5. Cost estimates: It is estimated that H.R. 3236 will result in a net reduction in outlays from the disability insurance trust fund. Budgetary authority is estimated to rise as a result of increased interest from the larger trust fund balances. The effects on the DI trust fund are shown below.

Estimated change in DI outlays and budget authority

	Millions
Estimated budget authority:	
Fiscal year:	
1980	[1]
1981	$13
1982	45
1983	99
1984	173
Estimated outlays:	
Fiscal year:	
1980	−17
1981	−337
1982	−620
1983	−924
1984	−1,212

[1] Less than $500,000.

H.R. 3236 affects outlays in other income maintenance programs and in the hospital insurance (HI) and supplemental medical insurance (SMI) trust funds.

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Required budget authority in the income maintenance programs which are entitlements would change by the estimated change in outlays. Budget authority in the HI and SMI change by the change in interest resulting from the changed trust fund balances.

The net effect on the total federal budget is given below:

Estimated net costs or savings to the Federal budget

	Millions
Estimated budget authority:	
Fiscal year:	
1980	$26
1981	51
1982	79
1983	120
1984	197
Estimated outlays:	
Fiscal year:	
1980	24
1981	−241
1982	−496
1983	−816
1984	−1,135

6. Basis for estimates: The tables below summarize the major provisions affecting the DI trust funds and the other federal offsets.

TABLE 1.—ESTIMATED COSTS AND SAVINGS TO THE DISABILITY INSURANCE TRUST FUND OF MAJOR PROVISIONS OF H.R. 3236

[By fiscal years, in millions of dollars]

	Fiscal year				
	1980	1981	1982	1983	198
Combined provisions to limit total family benefit and reduce the number of dropout years for younger workers	−72	−244	−439	−615	−773
65 percent preadjudicative review of initial determinations by fiscal year 1982	−8	−35	−99	−199	−301
Review of continuing disability cases once every 3 yrs	23	16	−1	−22	−42
Reimbursement to States for vocational rehabilitation only when recipient is successfully rehabilitated	0	−118	−129	−141	−154
More detailed notices of denials	19	20	21	22	23
Costs to DI of other sections	21	24	27	31	35
Total DI trust fund savings	−17	−337	−620	−924	−1,212

[1] Savings of the DI trust fund are partially offset by costs to other income maintenance and health programs. In addition, certain provisions of this bill affect the SSI program. The impact of this bill on these other programs is shown in table 2.

TABLE 2.—ESTIMATED CHANGE IN OUTLAYS IN OTHER FEDERAL INCOME MAINTENANCE PROGRAMS AND TO THE HI AND SMI TRUST FUNDS FROM PROVISIONS OF H.R. 3236

[In millions of dollars]

	Fiscal year				
	1980	1981	1982	1983	1984
Cap on family benefits and reduced number of dropout years:					
Federal income maintenance programs estimated outlays	11	39	67	93	113
2 12-mo trial work period and 2 yr extension of medicare:					
HI Estimated outlays	11	38	61	67	73
SMI Estimated outlays	7	25	39	43	47
Increased review of initial DI awards:					
HI Estimated outlays	0	0	−2	−8	−26
SMI Estimated outlays	0	0	−1	−5	−17
Periodic review of continuing DI cases:					
HI Estimated outlays	−2	−5	−9	−14	−19
SMI Estimated outlays	−1	−3	−6	−9	−12
Supplemental security income [1]	15	2	−25	−59	−82
Total estimated outlays	41	96	124	108	77

[1] These costs or savings to SSI represent administration estimates resulting from provisions to increase the preadjudicative review of initial allowances and implementation of the periodic review of continuing DI cases.

BEST DOCUMENT AVAILABLE

Section 2 and 3—Limitations on Total Famil Benefits in Disability Cases, and the Reduction in the Number of Drop-out Years for Younger Disabled Workers

Section 2 changes the way the maximum family benefit is computed by providing that the total family benefit not exceed 80 percent of average indexed monthly earnings (but not to fall below the primary insurance amount) or 150 percent of the worker's primary insurance amount. Section 3 reduces the number of "drop-out" years that may be taken for calculating AIME for younger workers. The provision, however, also allows one drop-out year for each year in which a worker had provided the principal care of a child under age 6 (but not to exceed 5 drop-out years).

Close to 30 percent of disabled worker beneficiaries receive dependents benefits and of this group an estimated 84 percent would receive reduced family benefits as a result of sections 2 and 3 combined. On average, the benefit for disabled worker beneficiaries with dependents would be lower by 15 percent under H.R. 3236. As indicated in the table below, total savings in fiscal year 1980 attributable to reduced benefits to beneficiaries with dependents are estimated to be $64 million, rising to $672 million in 1984. Some lower income beneficiaries, however, would receive offsetting increases in income maintenance payments estimated to be $8 million in 1980, rising to $83 million by 1984. As indicated in the table, smaller savings in DI payments and costs in terms of increased income maintenance payments are estimated for workers without dependents benefits as a result of the drop-out provision.

CBO estimates are based on a sample of disabled workers (and their families) awarded benefits between 1973 and 1976. In order to project benefits for workers first coming on the rolls in 1980, the earnings histories of the workers in the sample were wage indexed and the new wage indexed formula was applied to these earnings. Benefits were adjusted to account for the higher level of AIME between 1973–1976 and 1980, 1981, 1982, and so on using CBO economic assumptions. Benefits were calculated under current (1980) law and under the provisions of H.R. 3236 to derive the change in benefits from current law in each year, 1980–1984.

ESTIMATED SAVINGS IN DISABILITY INSURANCE PAYMENTS AND INCREASES IN FEDERAL INCOME MAINTENANCE PAYMENTS ARISING FROM H.R. 3236 PROVISIONS LIMITING TOTAL FAMILY BENEFIT AND REDUCING THE NUMBER OF DROPOUT YEARS FOR YOUNGER WORKERS

[In millions of dollars]

	Fiscal year				
	1980	1981	1982	1983	1984
Workers with dependents benefits:					
Savings in DI benefits	64	216	387	539	672
Offsetting increases in Federal income maintenance payments	8	28	49	67	83
Net savings in Federal outlays	56	188	338	472	589
Workers without dependents benefits:					
Savings in DI benefits	8	28	52	76	101
Offsetting increases in Federal income maintenance payments	3	11	18	26	30
Net savings in Federal outlays	5	17	34	50	71
Total: All workers:					
Total savings in DI benefits	72	244	439	615	773
Total increases in Federal income maintenance payments	11	39	67	93	113
Net savings in Federal outlays	61	205	372	522	660

The estimate assumes that 150,000 disabled workers with dependents would be awarded benefits in 1980 and that the number of new awards for this category of workers would decline slightly each year, reflecting the general decline in family size. The savings in benefits were applied to each cohort of new awards and adjustments were made for subsequent terminations in family benefits due to various factors—death, aging of children, recovery.

The estimates given do not assume any change in beneficiaries as a result of the reduction in benefits. Based on past experience, however, one could expect some reduction in the number of disabled workers applying for benefits. A CBO study indicates that a 1 percent reduction in benefits has been associated with a 0.85 percent reduction in beneficiaries. Allowing for this factor could lead to an additional reduction in DI outlays of $200 to $400 million by 1984.

Sections 6 and 7—Expansion of Trial Work Period and Elimination of Requirement that Months in Medicare Waiting Period Be Consecutive

These provisions extend the trial work period for disabled workers by an additional 12 months for a total of 24 months. Although cash benefits will still be terminated after the first 12 months as under current law, medicare coverage will be extended for three more years to those who continue to work beyond the first 12 month period. In addition, the provisions grant immediate resumption of medicare coverage (no 24 months waiting period) for those who return to the rolls after a period of time off the rolls.

These provisions are expected to have a negligible effect on cash benefit payments to disabled workers, although they will result in added costs to the medicare hospital insurance (HI) and supplementary medical insurance (SMI) programs. Based on an enactment date of October 1, 1980, benefits in these programs are estimated to increase as follows:

	Millions
HI:	
Fiscal year:	
1980	11.0
1981	37.8
1982	60.6
1983	66.6
1984	73.1
SI:	
Fiscal year:	
1980	7.1
1981	24.5
1982	39.3
1983	43.1
1984	47.3

Medicare costs increase partly because of the expanded entitlement to medicare for those who would normally terminate benefits after their original 12 month trial work period. Based on recent data on the number of workers leaving the rolls after completing a trial work period it is estimated that 20,000 workers would leave the rolls in fiscal year 1980 and become eligible for extended medicare benefits at an estimated average annual cost to $880 in HI and $570 in SMI per eligible disabled worker. These average costs are expected to increase by 9 percent a year.

The remainder of medicare cost increases are incurred because those who normally return to the rolls after a period off the rolls will have

their medicare benefits reinstated without a waiting period. About 40,000 workers are estimated to terminate DI benefits in 1980 (based on recent experience) for reasons other than completion of the trial work period (such as recovery): Of this group an estimated 5,000 persons are expected to return to the rolls within the year, thereby becoming eligible for resumption of medicare.

With respect to the effect of these provisions on DI cash benefit payments, some workers may be encouraged to work beyond the first 12 month trial period because of the continued medicare coverage and this would ultimately produce savings. On the other hand, some workers may find it easier to return to the rolls because of the elimination of the waiting period and this would increase costs. These incentive effects, however, are expected to have only a minimal net effect on the number of disabled worker beneficiaries.

Section 8.—Disability Determinations, Federal Review of State Agency Allowances

This section directs the Secretary of Health, Education and Welfare to expand the preadjudicative review of all initial disability allowances. This review is to be 15 percent in fiscal year 1980, 35 percent in 1981, and 65 percent in 1982.

The estimate of the net savings resulting from this provision is based on the methodology developed in a June 1978 study by CBO. This study used data on the gross percentages of initial state allowances returned by BDI to the states and the percentage of those subsequently denied, contained in the print, "Disability Insurance Program, 1978," Social Security Subcommittee of the Committee on Ways and Means, February 1978. From a 6 month review of 6,299 Title II initial disability allowances, 23.6 percent were returned to the states and 22.1 percent of these were denied. Using these two percentages, the number of initial allowances denied can be estimated. Allowances were made in the estimate for the man year costs of implementation, inflation and for normal deterioration from the DI rolls. Individuals who are denied DI benefits also lose the medicare benefits to which they would have been entitled after a two year waiting period.

Estimated savings to the DI as well as the hospital insurance and supplementary medical insurance trust funds are as follows:

	Millions
DI cash benefits:	
Fiscal year:	
1980	−$88
1981	−35
1982	−99
1983	−199
1984	−301
HI benefits:	
Fiscal year:	
1980	0
1981	0
1982	−2
1983	−8
1984	−26
SMI benefits:	
Fiscal year:	
1980	0
1981	0
1982	−1
1983	−5
1984	−17

Section 9.—Information to Accompany Secretary's Decisions as to Claimants' Rights

This section requires the Secretary of HEW to provide a detailed explanation to an applicant denied a disability award of the reasons for the denial, and a shorter notice to those whose awards are allowed. Taken literally, to provide each applicant a ". . . list of the evidence of record and a summary of the evidence . . ." in an understandable form could require a considerable effort. The administration estimates that increased manpower needs to implement this provision only for DI determinations would cost as follows:

DI:

Fiscal year:	*Millions*
1980	$19
1981	20
1982	21
1983	22
1984	23

CBO agrees that a lengthy response to each applicant could add these amounts to costs. If this provision is not interpreted to mean that brief letters must also be sent to all DI allowances, approximately 20 percent would be saved from these costs. If, in addition, OASI applicants are also to receive this information, then there would be considerable cost to the OASI trust fund. It should be pointed out however, that if this provision were interpreted by the Administration to require only a brief note to the denied DI applicant, then these costs could fall by one-half or more.

Section 13.—Vocational Rehabilitation Services for Disabled Individuals

This provision would grant state vocational rehabilitation agencies payments for having rehabilitated a disabled recipient only if that recipient has been successfully returned to work.

The provision is meant to be an incentive for states to encourage rehabilitation, since very few DI recipients currently are terminated for this reason. This section is effective as of the start of fiscal year 1981. Savings from this provision represent most of the costs now being paid to the states under current law for rehabilitation services and are estimated to be as follows:

DI:

Fiscal year:	*Millions*
1980	0
1981	−$118
1982	−129
1983	−141
1984	−154

Section 17—Periodic Review of Continuing Disability Cases

This section requires all non-permanent continuing disability cases to be reviewed every three years. In the middle of 1977, a 100 percent yearly review (since reduced to 50 percent) was instituted of all continuances of "diaried" cases where recovery seemed probable. It is unclear if many (or most) of these cases are identical to those to be deemed non-permanent, but it allows a way to estimate a probable savings from this provision (although there is no current formal definition of a non-permanent DI case). The current review is believed to

be partially responsible for the .8 percent increase in terminations since 1976 (about 20,000 cases). If one-half of these terminations were due to this continuing disability review, then by 1982 a total of 10,000 cases would have been terminated which might not have been. Manpower costs are based on Administration estimates of their potential needs to review the additional cases. Assuming an equal implementation over the three year period in which all cases must be reviewed, the five year, costs or savings to DI, HI and SMI are estimated as follows:

	Millions
DI:	
Fiscal year:	
1980	$23
1981	16
1982	−1
1983	−22
1984	−42
HI:	
Fiscal year:	
1980	−2
1981	−5
1982	−9
1983	−14
1984	−19
SMI:	
Fiscal year:	
1980	−1
1981	−3
1982	−6
1983	−9
1984	−12

This section can also be interpreted as directing the social security administration to formalize the type of review they are already doing. If that is the case, and the intent of the provision, there conceivably could be no costs or savings to the provision.

OTHER SECTIONS

The remaining sections of the bill have only minor costs. The provisions to allow disabled workers to deduct impairment related work expenses from earnings in determining substantial gainful activity (section 5) accounts for most of the cost in this group. Other provisions direct the Department of Health, Education and Welfare to pay for certain travel expenses, conduct a number of demonstration projects and to pay for or collect costs of other minor services. These total costs are shown below.

	Millions
DI:	
Fiscal year:	
1980	$21
1981	24
1982	27
1983	31
1984	35

7. Estimate comparison: None.

8. Previous CBO estimates: H.R. 2054, as reported to the full committee on March 20, 1979.

9. Estimate prepared by: Stephen Chaikind; June O'Neill.

10. Estimate approved by:

C. G. Nuckols
(For James L. Blum, Assistant Director
for Budget Analysis).

VII. Additional Views of Hon. Sam M. Gibbons, Richard A. Gephardt, Cec Heftel, Bill Frenzel, Jim Martin, and John H. Rousselot to H.R. 3236, The Disability Insurance Amendments of 1979

When H.R. 3236, the Disability Insurance Amendments of 1979, was considered in the Committee on Ways and Means, I offered a simple amendment to section 2 that would limit total disability insurance (DI) family benefits for future beneficiaries to 130 percent of a worker's insurance amount. We believe this is a level at which a worker and his or her family would be adequately protected during the period of disability while still providing that worker an incentive to return to work at his or her normal (higher) rate of pay. The committee bill would limit this to 150 percent of a worker's insurance amount.

Under the committee bill, a worker who becomes disabled under the Social Security System is entitled to benefits which are computed on the basis of the smaller of the worker's average indexed monthly earnings (AIME) or the worker's primary benefits (PIA), that is the insurance amount. My amendment would place the limit at the smaller of 80 percent of a worker's AIME or 130 percent of the worker's PIA (80/130). The Subcommittee on Social Security proposed instead a total DI family benefit limit of 80/150. Unfortunately, we fell 2 votes short when the amendment was considered and defeated by a vote of 14 yeas to 16 nays. It is obvious that the committee is fairly well split on this issue and that is why the undersigned Members offer these additional views.

Liberal disability benefits induce both an increase in the number of cases approved and the prolongation of disability. From a social and humanistic point of view, we are presented with a dilemma, namely, how we can provide adequate benefits to those unfortunate individuals who become and remain truly disabled, without removing or greatly reducing the incentive to overcome the disability and return to work. From a taxpayer's point of view, rising payroll taxes are and have been necessary to keep solvent the troubled disability insurance system, which includes excessive disability benefits for high-income families, particularly two-earner families.

For example, if a man and his wife with one child each earn $12,000, their net income is $16,600. If one of them should become disabled and one continues to work, under current law their net income will be $16,700. The committee bill would not change that result. Thus, there is an economic disincentive not to return to work. I think this result should be changed if our disability insurance system is going to survive. My sense of justice requires that when disabled workers return to work, their family income should increase. Accordingly, my amendment to change the earnings replacement ratio to 80/130 would provide this couple with $15,700 net income, or an economic incentive to return to work of $1,000.

As table I of the following tables indicates, our amendment would provide greater economic incentives to disabiltiy recipients at all wage levels above $5,000. Its primary effect would be on high income families. A person earning $5,750 would lose $4.43 per year or $8.53 per week relative to the committee bill; a person earning $16,000 would lose $1,232 per year or $23.70 per week. For maledisabled workers in two earner families, the percent of workers with over 90 percent replacement rates would be reduced to 35 percent from 67 percent of all present DI beneficiaries. See table II. Many of these workers have spouses who can work. Furthermore, while the amendment only affects families with children, the proposal does not eliminate dependents benefits. Lower income workers who become disabled many still receive support from SSI, AFDC, food stamps, school lunch and other child nutrition programs, housing programs, education porgrams, medicare, medicaid, the medically needy program, worker's compensation, veterans benefits, black lung benefits, and civil service to name a few.

The point is, all of the income maintenance concerns of low income workers should not be solved by social insurance programs like DI. We should not set DI benefit levels as if this was the family's only means of support. Social security was never intended by either liberals or conservatives to provide over 80, 90, or even over 100 percent of predisability benefits. But as table IV indicates, under current law some two-earner families may stand to make more drawing disability than they did before becoming disabled or would after they return to work. Unfortunately, the committee bill allows this to continue in some instances.

We submit that the proposed amendment solves the social and humanistic dilemma faced by those of us who are concerned about the DI system. It also goes further than the committee's bill in answering the taxpayer's legitimate complaint that the payroll tax rates have risen too high and must be rolled back.

It is estimated by both Social Security actuaries and the Congressional Budget Office that utilizing an 80/130 formula would save an additional 430 million per year by 1984 relative to the committee bill. In the 4-year period from 1981 to 1984, we could save $1 to $1.2 billion. Such savings help to balance the Federal budget. They can also be passed on to high- anl low-income workers in terms of greater rollback in the payroll tax rate when social security/DI financing is considered late this year or early next year.

Time may be running out on the disability insurance system and our taxpayer's willingness to support it. We think the time for decision is now.

Respectfully submitted.

SAM M. GIBBONS.
RICHARD A. GEPHARDT.
CEC HEFTEL.
BILL FRENZEL.
JIM MARTIN.
JOHN H. ROUSSELOT.

BEST DOCUMENT AVAILABLE

TABLE I.—IMPACT OF BENEFIT LIMIT PROPOSALS AT VARIOUS BENEFICIARY LEVELS

[Benefit amount—disabled worker and 2 dependents, 1980]

Annual indexed earnings	Current law	80 percent of AIME administration proposal (H.R. 2854)	80 percent of AIME or 150 percent of PIA (H.R. 3236)	80 percent of AIME or 130 percent of PIA	Amount of reduction relative to committee bill
1,750	2,363	1,576	1,576	1,576	0
4,250	4,077	3,400	3,400	3,400	0
5,750	5,039	4,600	4,600	4,157	443
7,500	6,560	6,000	5,636	4,884	752
9,250	8,084	7,400	6,476	5,613	863
10,900	8,795	8,720	7,268	6,299	969
12,650	9,546	9,546	8,109	7,028	1,081
14,250	10,309	10,309	8,845	7,666	1,179
16,000	10,776	10,776	9,238	8,006	1,232

TABLE II.—ESTIMATED DISTRIBUTION OF DISABLED WORKERS WITH DEPENDENTS' BENEFITS BY RATIO OF POST-DISABILITY INCOME TO PREDISABILITY DISPOSABLE INCOME UNDER VARIOUS PROPOSALS

	Estimated number of DI awards (thousands)	Postdisability disposable income as a percent of predisability disposable income [1]			
		Below 90	90 to 100	Above 100	Total
Male Disabled Worker, 2-earner family	54.9				
Current law		4	32	64	100
Committee bill		33	46	22	100
80/150		65	25	10	100
Male disabled worker, 1-earner family	55.5				
Current law		21	65	14	100
Committee bill		74	17	8	100
80/150		78	14	8	100
Female disabled worker, 2-earner family	25.5				
Current law		0	6	94	100
Committee bill		2	32	66	100
80/150		8	40	52	100

[1] Predisability disposable income is the sum of average wage indexed earnings of worker (since 1951 or age 21), earnings of spouse preceding disability and property income preceding disability, less estimated taxes and work expenses. Estimate of income maintenance payments was added to obtain total disposable income.

Postdisability income is the sum of spouse earnings after disability and estimated property income, less estimated taxes and work expenses. Estimate of means-tested income maintenance payments was added to obtain total disposable income. Payments from private or governmental pensions, veterans' benefits, and workmen's compensation are not included. Post and predisability income were both indexed to same year for calculating ratios.

Source: Based on sample DI awards between 1973 and 1976 merged with longitudinal earners histories and SSA and census data on worker characteristics and income sources.

TABLE III.—*Examples of economic incentives to return to work*

Example 1—Man, wife each earning $12,000—with 1 child:	
Net income prior to disability	$16,600
Net income if one becomes disabled and one continues to work	16,700
Net income under subcommittee bill	16,700
Economic incentive to return to former job	−100
Economic incentive to take a job earning $6,000 a year	−3,300
Net income under 80/130	15,700
Economic incentive to return to former job	1,000
Example 2—Man earning $12,000, wife earning $6,000—with 2 children:	
Net income prior to disability	$13,400
Net income if male becomes disabled, female continues to work (current law)	14,200
Net income under subcommittee bill	12,800
Economic incentive to return to work	600
Net income under 80/130	11,900
Economic incentive to return to work	1,500
Example 3—One earner, spouse and child where earner earns $10,000:	
Net income prior to disability	$8,000
Net income when earner becomes disabled (current law)	7,900
Net income under subcommittee bill	6,500
Economic incentive to return to work	1,500
Net income under 80/130	5,600
Economic incentive to return to work	2,200

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TABLE IV.—POSTDISABILITY DISPOSABLE INCOME AS A PERCENT OF PREDISABILITY DISPOSABLE INCOME UNDER VARIOUS WAYS OF LIMITING FAMILY BENEFITS FOR DISABLED WORKER BENEFICIARIES WITH DEPENDENTS

	Current law	80 percent of AIME/150 percent of PIA	80 percent of AIME/130 percent of PIA
Male disabled worker family:			
1 earner	94	85	78
2 earner	103	93	87
Average	98	89	83
Female disabled worker family:			
1 earner	96	93	91
2 earner	109	101	99
Average	104	98	96

Source: CBO simulation of persons awarded benefits in 1980 based on a sample of awards from 1973–76.

TABLE V.—IMPACT OF BENEFIT LIMIT PROPOSALS AT VARIOUS EARNINGS LEVELS INCLUDING WELFARE[1]

Earnings	Predisability disposable income	Postdisability disposable income		
		Current law	H.R. 3236	80/130
$2,000	$3,423	$6,048	$6,048	$6,048
$4,000	4,884	6,048	6,048	6,048
$6,000	5,923	5,588	5,276	4,865
$8,000	6,666	6,734	5,945	5,426
$10,000	7,966	7,931	6,493	5,996

[1] Welfare programs included in this analysis are AFDC, SSI, and food stamps.

VIII. Supplemental Views of Hon. Richard A. Gephardt and Hon. Cec Heftel on H.R. 3236, the Disability Insurance Amendments of 1979

While we are very supportive of the basic provisions of H.R. 3236 to reduce program costs and improve work incentives for beneficiaries, there is one area of improvement which has not been included in the bill. Briefings on H.R. 3236 for members of the House Ways and Means Committee brought to light the fact that disability insurance was provided on the basis of not just medical disability but also utilizing vocational factors such as age, education and work experience. This produces higher costs for the program and greater ambiguity in determining who should become a beneficiary. We will be undermining the credibility and financial stability of the system if we provide benefits at levels for which the people or government are unwilling to pay.

A great step forward can be made in terms of fiscal responsibility by using only medical factors for determining disability for insurance applicants under 55 years of age, while continuing to use medical and vocational factors for persons 55 years of age and over. This proposed amendment would only affect cases occurring in the future and would have no impact on cases which have been decided in the past. For individuals under 55 who would be denied disability benefits because medical evidence was insufficient, existing social programs would be available to provide assistance. When offered during full committee markup, this amendment failed by just one vote (13 nays to 12 ayes). There is obvious committee support for this proposal and it will be offered again on the House floor.

The amendment would result in savings to the system in excess of $500 million per year by 1984. That sum becomes significant as a part of an overall effort to make social security once again solvent. The administration of the disability program would be further streamlined by the reduction in the number of cases in which vocational factors must be considered. Currently, a disproportionate percentage of cases reaching the hearings and appeals stages involve the consideration of vocational factors. New benefit awards could be expected to be cut by approximately 5 percent with this change.

The trend in recent years toward less reliance on vocational factors has been encouraging, but the proposed amendment is necessary to assure that benefits awarded be appropriate under the original intent of the disability program. In conclusion, we hope to take every step possible toward restoring confidence in the stability and credibility of the Social Security system.

Respectifully submitted.

Richard A. Gephardt.
Cec Heftel.

Calendar No. 438

96TH CONGRESS
1st Session

SENATE

REPORT
No. 96-408

SOCIAL SECURITY DISABILITY AMENDMENTS OF 1979

REPORT

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ON

H.R. 3236, A BILL TO AMEND TITLE II OF THE SOCIAL SECURITY ACT TO PROVIDE BETTER WORK INCENTIVES AND IMPROVE ACCOUNTABILITY IN THE DISABILITY INSURANCE PROGRAMS, AND FOR OTHER PURPOSES

NOVEMBER 8 (legislative day, NOVEMBER 5), 1979.—Ordered to be printed

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Calendar No. 438

96TH CONGRESS
1st Session

SENATE

REPORT
No. 96-408

SOCIAL SECURITY DISABILITY AMENDMENTS OF 1979

NOVEMBER 8 (legislative day, NOVEMBER 5), 1979.—Ordered to be printed

Mr. LONG, from the Committee on Finance, submitted the following

REPORT

[To accompany H.R. 3236]

The Committee on Finance, to which was referred the bill (H.R. 3236) to amend title II of the Social Security Act to provide better work incentives and improve accountability in the disability insurance programs, and for other purposes, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill as amended do pass.

I. Summary

DISABILITY INSURANCE

Present benefit structure.—Social security disability insurance benefits are based on an individual's previous earnings. The formula for determining benefit amounts is the same for disability benefits as for social security retirement benefits. The benefit level is arrived at by applying a formula to the average earnings the individual had over a period of years which approximates the number of years in which he could reasonably have been expected to be in the work force. For a retired worker, this period is equal to the number of years between the ages of 21 and 62. For a disabled worker, the number of years of earnings to be averaged ends with the year before he became disabled. In either case, the resulting averaging period is reduced by five. The basic benefit amount may be increased if the worker has a dependent spouse or children. The combined benefit for the worker and all dependents is limited by a family maximum provision to no more than 150 to 188 percent of the worker's benefit alone.

B. Provisions Relating to Disability Benefits Under OASDI Program

LIMIT ON FAMILY DISABILITY INSURANCE BENEFITS

(Section 101 of the Bill)

Present law.—The social security disability insurance program determines the amount of benefits payable based on an individual's previous earnings. The formula for determining disability benefits is the same as for retirement benefits. The benefit level is arrived at by applying a formula to the average earnings the individual had over the course of a period of years which approximates the number of years in which he could reasonably have been expected to be in the work force. For a retired worker, this period is equal to the number of years between the ages of 21 and 62. For a disabled worker, the number of years of earnings to be averaged ends with the year before he became disabled. In either case, the resulting averaging period is reduced by 5.

The basic benefit amount may be increased if the worker has a dependent spouse or children. Benefits for the spouse are payable if the spouse is over age 62 or if the spouse is caring for minor or disabled children. Benefits for children are payable if they are under age 18 or are disabled (as a result of a disability which existed in childhood) or if they are full-time students over age 18 but under age 22. The combined benefit for the worker and all dependents is limited by a family maximum provision to no more than 150 to 188 percent of the worker's benefit alone.

The benefits payable to disabled workers cover a broad range from a minimum of $122 monthly to a maximum (for a worker who became disabled in 1978) of about $730. The average benefit for all disabled workers in June 1979 was $320 per month. The average total family payment for disabled workers with dependents was $639 per month.

The benefit amounts payable under the social security disability insurance program have increased very greatly over the past decade. In part, these increases simply reflect the percentage increases in social security benefit levels resulting from legislation and from the automatic cost-of-living increase provisions instituted by the 1972 amendments. Wage growth in the economy also contributes to increased benefits since social security benefit amounts are determined by applying the benefit formula to an individual's average wages under social security. The impact of wage growth over the past several years has tended to be reflected in disability benefit increases more than in retirement benefit increases. The rate of growth in disability benefits as compared to retirement benefits is shown in the table below.

TABLE 14.—INCREASES IN BENEFITS AWARDED TO RETIRED AND DISABLED WORKERS, 1969 TO 1978

Year	Retirement awards			Disability awards		
		Percentage			Percentage	
	Average amount	Over 1969	Over prior year	Average amount	Over 1969	Over prior year
1969	$106			$118		
1970	124	17	17	140	19	19
1971	138	30	11	157	33	12
1972 [1]	169	59	22	193	64	23
1973	170	60	1	197	67	2
1974 [2]	192	81	13	217	84	10
1975 [2]	214	102	11	243	106	12
1976 [2]	234	121	9	271	130	12
1977 [2]	255	141	9	295	150	9
1978 [2]	278	162	9	328	178	11

[1] September–December average.
[2] June–December average.

Source: Social Security Bulletin.

The average disability award has increased from $118 to $328 over the 10-year period 1969–78. This is a 178-percent increase. During the same period of time, the cost of living (as measured by the Consumer Price Index) rose by about 80 percent. A part of this rapid growth in disability benefit levels is attributable to the over-indexing aspects of the automatic increase provisions enacted in 1972. Under the revised benefit formula adopted in the 1977 Amendments, initial benefit levels will continue to increase at a rate in excess of the inflation rate but to a lesser extent than under the prior law.

One of the reasons which has been advanced to explain the rapid growth in the disability program in recent years is that the increased benefit levels have made it more likely that any given individual will become and remain a beneficiary. When benefit levels were very low, an individual with a disability might find it economically advantageous to continue working even though his impairment limited his earnings to quite low levels. Similarly, an individual who became a recipient had a potential for significantly increasing his family income by participating in a program of rehabilitation. The higher benefit levels now prevailing in the program substantially reduce the extent to which a disabled person would find it advantageous to remain in or return to employment.

While it is possible to draw a general conclusion that increased benefit levels appear to have contributed to the rapid growth of the program which occurred in the early and mid-1970's, there is no simple rule of thumb for determining the optimum benefit level which balances the desire for reasonable adequacy against the desire to maintain a reasonable incentive for continued employment or rehabilitation. Clearly, this line falls somewhere below a level of 100 percent of prior earnings, since disability benefits are tax free and are also free of various other costs an individual would probably incur in working. The availability of medicare for those who have been on the disability rolls for at least two years is also a factor. Considerable analysis has been conducted of the relationship between the initial benefit level and prior earnings. This analysis has shown that there are numerous instances where disability insurance benefits come close to or even exceed the worker's prior earnings.

In transmitting the Administration's proposed changes to the DI program in March of this year, the Secretary of HEW pointed out that 6 percent of DI beneficiaries receive more through their DI benefits alone than their net earnings while working, and that 16 percent have benefits which exceed 80 percent of their prior net earnings. The Secretary's analysis was based on comparisons of benefit awards to the workers' highest 5 years of indexed earnings. Using the high-five years of indexed earnings may tend to understate the prevalence of high replacement rates.

The following table, provided by the Social Security Administration's actuaries, which is based on a sample of approximately 10,000 DI awards made in 1976, shows the replacement rates resulting from those awards under two illustrative approaches of measuring replacement rates. The first approach encompasses the period of earnings used to compute average indexed monthly earnings (AIME) as the base to which benefits are compared. The second approach uses the highest 5 years of indexed earnings during the 10-year period immediately preceding the onset of the disabling condition. These replacement rates represent the percent of gross earnings which the DI benefits replace. Replacement rates would be even higher when "net earnings" are considered.

TABLE 15.—DI REPLACEMENT RATES COMPUTED FROM 2 DIFFERENT MEASURES OF DR DISABILITY EARNINGS

Replacement rates [2] (1979 PIA) levels	Awards at each level of earnings replacement [1]			
	Using AIME		Using high 5 yr of indexed earnings in last 10	
	Number of cases	Percent of total	Number of cases	Percent of total
Under 30 percent	0	0	268	3
30 to 39 percent	79	1	2,930	31
40 to 49 percent	3,669	38	2,168	23
50 to 59 percent	1,456	15	1,184	12
60 to 69 percent	947	10	1,353	14
70 to 79 percent	1,215	13	771	8
80 to 89 percent	1,477	15	526	5
90 to 99 percent	181	2	148	2
100 percent and over	561	6	237	2
Total sample	9,585	100	9,585	100
Average replacement rate (percent)	58		49	

[1] These awards include both individual and family benefits where applicable. The actual awards were made before a "decoupled" system was put into effect. However, the awards were recomputed for sample purposes as if a decoupled system existed to give some sense of the longer-range direction of DI replacement rates.

[2] Represents replacement of gross earnings.

Both approaches to measuring replacement—i.e., either long or recent periods of a worker's earnings history—show that there are a substantial number of DI awards which by themselves result in replacement rates in excess of predisability earnings. Using 80 percent of gross predisability earnings as an approximation of predisability disposable earnings, about 23 percent of the awards in the sample were above that level using AIME as the base period for measurement, and approximately 10 percent of the awards in the sample were above that level using the high 5 years of indexed earnings during the 10-year period prior to the onset of disability as the base period for measurement. Approximately two-thirds of these cases involved the payment of dependents benefits in addition to those of the worker.

Actuarial studies in both the public and private sector have indicated that high replacement rates may constitute an incentive for impaired workers to attempt to join the benefit rolls, and a disincentive for disabled beneficiaries to attempt rehabilitation or return to the work force. An analysis by the social security actuaries has indicated:

The average replacement ratio of newly entitled disabled workers with median earnings and who have qualifying dependents increased from about 60 percent in 1967 to over 90 percent in 1976, an increase of about 50 percent. During this time the gross recovery rate decreased to only one-half of what it was in 1967. High benefits are a formidable incentive to maintain beneficiary status especially when the value of medicare and other benefits are considered. We believe that the incentive to return to permanent self-supporting work provided by the trial work period provision has been largely negated by the prospect of losing the high benefits.

("Experience of Disabled Workers Benefits Under OASDI, 1972–1976," actuarial study No. 75, June 1978.)

An actuarial consultant's report to the Committee on Ways and Means also concludes:

* * * disability income dollars are, in general, much more valuable and have much more purchasing power than earned dollars. The DI benefits are fully tax exempt, as are insured benefits except for employer provided benefits in excess of $100 per week. For a worker with a spouse and a child, paying an average State income tax, 50 percent of salary in the form of disability benefits may well equal 65 percent or more of gross earnings after tax. In addition, the disabled individual is relieved of many expenses incidental to employment such as travel, lunches, special clothing, union or professional dues, and the like.

It is a cause for deep concern that gross ratios of 0.600 or more apply to all young childless workers at median or lower salaries and to nearly all workers with a spouse and minor child for earnings up to the earnings base. In other words, all workers entitled to maximum family benefits are overinsured except older workers whose earnings approach the earnings base, middle-aged workers who earn not more than the earnings base, and young workers except those earning substantially more than the earnings base.

Although these excessive replacement ratios have not been in effect long enough to have been fully reflected in the disability experience, overly liberal benefits may have played some part in the 47 percent increase, between 1968 and 1974, in the average rate of becoming disabled. Other than the indexing provisions, statutory changes during this period could have had no great effect. There is no evidence that the health of the nation has deteriorated. Rising unemployment has clearly been a factor, but the increasing attractiveness of the benefits must also be an important influence.

(U.S. Congress, House, Subcommittee on Social Security of the Committee on Ways and Means, *Report of Consultants on Actuarial and Definitional Aspects of Social Security Disability Insurance*, 94th Congress, 2d Session, 1976.)

Testimony heard by the Finance Committee from a private actuary on behalf of a number of insurance companies includes similar observations. This actuary states the following about private disability insurance experience:

> * * * claim costs increase dramatically when replacement ratios exceed 70 percent of gross earnings, and are unsatisfactory when replacement ratios exceed 60 percent of gross earnings . . . Expected claims is the level of claim costs that is assumed in determining premiums, so a ratio of 100 percent would be what a company would expect to achieve when it sets rates . . . large exposures show claims at 87 percent of expected when the replacement ratio was 50 percent, 93 percent of expected when the replacement ratio was 50 percent to 60 percent, 106 percent when the replacement ratio was between 60 percent and 70 percent, and a jump in the ratio of actual to expected claims of 219 percent—more than double what the premium allowed—when the replacement ratio exceeded 70 percent of gross earnings.

(U.S. Congress, Senate, Committee on Finance, testimony of Gerald S. Parker on H.R. 3236, Social Security Disability Legislation, October 10, 1979.)

Analysis by the Congressional Budget Office further indicates that it is not correct to assume that a typical disabled worker family is dependent entirely or almost entirely on social security benefits. Disabled workers in families with children derive on average only about 40 percent of their total cash income from social security benefits. The analysis indicates that very few worker families have more than a 10 percent reduction in disposable income as a result of disability.

In summary, this analysis shows that the combined impact of high social security disability insurance replacement rates and substantial other sources of family income is to insulate disabled worker families, as a group, from any major reduction in income as a result of their disability.

Committee bill.—The committee is concerned about the impact these high benefit levels and replacement rates have had on the growth of the program, in that they may have caused both incentives for impaired workers to stop working and apply for benefits, and disincentives for DI beneficiaries to leave the benefit rolls. The Committee further is concerned about the inappropriateness of having situations where benefits exceed predisability earnings in a program intended primarily to replace lost earnings.

The Committee bill would address these concerns through a provision which limits total DI family benefits to an amount equal to the smaller of 85 percent of the worker's AIME or 160 percent of the worker's PIA. Under the provision no family benefit would be reduced below 100 percent of the worker's primary benefit. The limitation would be effective only with respect to individuals becoming entitled to benefits on or after January 1, 1980, based on disabilities that began after calendar year 1978. The limitation would not apply to individuals who join the benefit roll after the effective date of the provision who were on the rolls (or had a period of disability) at another time prior to calendar year 1980. This will preclude the new limit on family benefits from applying to anyone who was on the roll in the past. Approximately 120,000 family units, encompassing 355,000 beneficiaries, will be affected by the limitation in the first full year after enactment.

The Secretary would be required to report to the Congress by January 1, 1985 on the effect of the limitation on benefits and of other provisions of the bill.

The committee further is concerned about situations where the payment of disability benefits to an individual from a number of public disability pension or like systems results in aggregate benefits which exceed the individual's predisability earnings. While coordination exists between the DI program and State worker's compensation programs for the purpose of keeping the two forms of disability benefits at an aggregate level no higher than the worker's net predisability earnings, there are numerous other Federal and State programs providing disability benefits or compensation which are not coordinated at all with the DI program. The General Accounting Office has already undertaken a study of the relationship between social security and workers' compensation under the existing provision. The Committee requests the General Accounting Office to also study the prevalence of multiple receipt of disability benefits from DI and other programs (in addition to worker's compensation), as well as various approaches to better coordinate the overall benefits provided to an individual for the purpose of precluding them from exceeding the worker's predisability earnings. This report and the recommendations of the General Accounting Office will be the subject of hearings which the committee intends shall be held next year by its subcommittee on social security.

REDUCTION IN DROPOUT YEARS

(Section 102 of the Bill)

Present law.—Under present law, workers of all ages are allowed to exclude 5 years of low earnings in averaging their earnings for benefit purposes.

Although the same general rules apply to determining benefits for disabled individuals and their dependents as to determining benefits for retired workers and their dependents, the application of these rules leads to somewhat different results. In general, benefit levels are apt to be higher for disabled workers because of the smaller number of years over which earnings must be averaged. This is particularly true for younger disabled workers for whom as few as two years may be used in determining the average earnings to which the benefit formula will be applied. For example, in the case of a worker who is disabled at age 29, the number of years used to determine his benefit is equal to the 7 years between the year in which he reached age 21 and the year in which he became disabled less the 5 drop-out years. His benefit is based on his earnings in those two years in which he had his highest earnings. For a worker age 50 or over this exclusion represents only 18 percent of his or her earnings history (5 years out of 28). It represents, however, a 71 percent exclusion for a 29-year-old (5 years out of 7).

Because earnings levels in the economy tend to increase from year to year, the advantage to the younger disabled worker of having his earnings averaged over a very few high years is magnified since the older worker is forced to include years when earnings levels were lower. Prior to the 1977 amendments, this problem was particularly severe since earnings were averaged at their actual values. The 1977 amendments lessened but did not eliminate this advantage by providing for the indexing of earnings to compensate for the impact of changing wage levels in the economy. Younger workers continue to have a substantial advantage both because statutory increases in the amount of

annual earnings subject to social security tax have been much greater in recent years than in earlier years and because individual wage patterns differ widely from average wage patterns. As a result, an individual whose benefits are based on the average of his earnings over his two, three, or four highest years of earnings is likely to have a significantly higher benefit than an older worker who must average his highest ten or twenty or more years of earnings.

Furthermore, data provided to the committee by the Social Security actuaries show that both the average replacement by age group and the incidence of replacement rates over 80 percent of prior earnings are considerably greater among younger workers than older workers. The following table constructed from the actuaries' data show these situations:

TABLE 16.—DISTRIBUTION OF DI REPLACEMENT RATES BY AGE GROUP OF DISABLED WORKERS

	Total		Replacement rate brackets, 80 percent and higher, using high-5 yr of earnings in last 10 as base period for measurement [1] (percent)			Average replacement rate (percent)
	Number of cases	Percent	80 to 89	90 to 99	100 and over	
Age at onset:						
Under 20	64	100	23	6	22	72
20 to 24	574	100	15	2	9	60
25 to 29	698	100	19	2	4	59
30 to 34	652	100	11	1	1	57
35 to 39	714	100	8	3	3	59
40 to 44	889	100	5	2	3	54
45 to 49	1,232	100	3	2	2	49
50 to 54	1,699	100	2	1	2	47
55 to 59	1,965	100	2	1	1	44
60 to 64	1,098	100	1	1	1	41
Total	9,585					49

[1] Based on 1979 PIA levels.

Note: 9,585 cases in sample, including workers both with and without dependents.

Committee provision.—In response to concern that the benefit structure gives undue advantage to younger workers, the committee provision would exclude years of low earnings in the computation of benefits according to the following schedule:

Worker's age:	*Number of dropout years*
Under 32	1
32 through 36	2
37 through 41	3
42 through 46	4
47 and over	5

The provision applies to all disabled workers who first become entitled to benefits after 1979. The provision would not apply to individuals who join the benefit roll after the effective date of the provision, who were on the roll (or had a period of disability) at another time prior to calendar year 1980.

While the committee believes that fewer drop-out years for younger workers will make the benefit structure more equitable for younger and older disabled workers, the committee felt that all workers regardless of age should have at least 1 drop out year.

Approximately 120,000 DI awards, involving 290,000 beneficiaries, will be computed under the new dropout year provision in the first full year after enactment.

MEDICARE WAITING PERIOD

(Section 103 of the Bill)

Present law.—At the present time, beneficiaries of disability insurance must wait 24 months after becoming entitled to benefits to become eligible for medicare. If a beneficiary returns to work and then becomes disabled again, another 24-month waiting period is required before medicare coverage is resumed.

Committee bill.—The committee has heard testimony that the fear of being forced to wait for medicare coverage throughout a second 24-month waiting period has acted as a deterrent to some beneficiaries who might otherwise attempt to return to the work force. In order to remove this work disincentive, the committee bill would eliminate the requirement that a person who becomes disabled a second time must undergo another 24-month waiting period before medicare coverage is available to him. The amendment would apply to workers becoming disabled again within 60 months, and to disabled widows, or widowers and adults disabled since childhood becoming disabled again within 84 months. In addition, where a disabled individual was initially on the cash benefit rolls, but for a period of less than 24 months, the months during which he received cash benefits would count for purposes of qualifying for medicare coverage if a subsequent disability occurred within those time periods. The provision would be effective for medicare benefits for services provided after June 1980. Approximately 30,000 persons are expected to be affected by this provision in the first full year after enactment.

EXTENSION OF MEDICARE COVERAGE FOR AN ADDITIONAL 36 MONTHS

(Section 104 of the Bill)

Present law.—Under present law medicare coverage ends when disability insurance benefits cease. Considerable testimony was given to the committee suggesting that this abrupt termination of medicare coverage poses a significant obstacle for many disabled workers to return to work, who are faced with the prospect of losing valuable hospital and other medical insurance coverage at a point when there is great uncertainty about their ability to sustain employment.

Committee bill.—In order to encourage disabled workers to attempt employment as well as to remove the possibility that incurring higher

health insurance premiums might discourage employers from hiring the disabled, the committee provision would extend medicare coverage for an additional 36 months after cash benefits cease for a worker who is engaging in substantial gainful activity but has not medically recovered. (The first 12 months of the 36-month period would be part of the new 24-month trial work period.) Approximately 30,000 persons are expected to be affected by this provision in the first full year after enactment.

C. Provisions Relating to Disability Benefits Under the SSI Program

BENEFITS FOR INDIVIDUALS WHO PERFORM SUBSTANTIAL GAINFUL ACTIVITY DESPITE MEDICAL IMPAIRMENT

(Section 201 of the Bill)

Present law.—The Social Security Act under present law uses an identical definition of disability for purposes of both the disability insurance program under title II of the Act and the SSI disability assistance program under title XVI of the Act.

The definition in the law reads as follows:

> SEC. 1614. (a) * * *
>
> (3)(A) An individual shall be considered to be disabled for purposes of this title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).
>
> (B) For purposes of subparagraph (A), an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect of any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.
>
> (C) For purposes of this paragraph, a physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.
>
> (D) The Secretary shall by regulations prescribe the criteria for determining when services performed or earn-

ings derived from services demonstrate an individual's ability to engage in substantial gainful activity. Notwithstanding the provisions of subparagraph (B), an individual whose services or earnings meet such criteria, except for purposes of paragraph (2), shall be found not to be disabled.

This definition does not establish any level of severity of an individual's medical condition as a test of whether or not he is disabled. Instead, the definition requires that there be present some medically determinable impairment and that that impairment be found to preclude the individual from engaging in "substantial gainful activity" (SGA). The concept of "substantial gainful activity" is, therefore, a key element in the definition of disability. Two individuals with identical medical conditions might properly receive different decisions as to whether or not they are disabled. Considering each individual's vocational background (education, experience, etc.), one may reasonably be found able to get a job at the substantial gainful activity level while the other may not.

The term "substantial gainful activity," is not defined in the statute. Rather, the Secretary of Health, Education, and Welfare is required to prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. These criteria have been expressed in regulations in the form of dollar amounts of earnings above which an individual would be presumed to be engaging in SGA, and therefore not disabled for purposes of the social security definition. The current SGA amount is $280 a month.

In recent years questions have been raised about the failure of the SSI program to remove individuals from disability status through rehabilitation and movement into employment.

A matter of particular concern is the fact that the program may operate in such a way as to actually discourage recipients from seeking employment. This work disincentive problem arises from the basic nature of the program which defines "disability" not by medical severity but rather, as noted above, in terms of incapacity for significant employment—substantial gainful activity. If an individual who has a very severe handicap does successfully perform any significant work activity, he has demonstrated that he no longer lacks the capacity for work. While he is permitted a trial work period during which he may continue to receive benefits, after this period he may be found ineligible. While his increased earnings will at least partially offset his loss of cash benefits, an SSI recipient may also face the loss of medicaid and social services since eligibility for those programs is generally tied to eligibility for at least one dollar of SSI benefits. Thus a severely disabled recipient contemplating the possibility of working may face a combined loss of benefits under the other programs which significantly outweigh the potential gain from earnings.

The committee is deeply concerned about these disincentive features because of the hardships they impose on severely disabled people who have the desire and motivation to seek a more independent life through work effort. At the same time, however, the committee is keenly aware that the disincentives to employment arise from the basic nature of the program as explained above. The committee feels it is necessary to move with great care in addressing those disincentives to avoid making unintended and undesirable changes in the fundamental scope and pur-

poses of the program. For this reason the committee cannot recommend the approach contained in the bill H.R. 3464 as passed by the House of Representatives.

The House-passed bill would have effectively and significantly liberalized the basic definition of disability under the SSI program by changing the definition of what constitutes substantial gainful activity. Under the House bill, an individual could be found "not disabled" on the basis of his earning capacity only if he were unable to earn as much as $481 for a single individual, and $690 for an eligible couple. (Any future automatic cost-of-living increases in the Federal SSI benefit would automatically increase the current basic SGA amounts.) These amounts would be further increased by the amount of any impairment-related work expenses. Thus the SGA level would vary from individual to individual depending on his impairment-related work expenses and on his marital status. A single individual with monthly expenses of $150 would have an SGA level of $631 a month or $7,572 a year. If this same individual had an eligible spouse his SGA level would be $840 a month or $10,080 a year.

The change in the definition of disability could change the program from one in which benefits are intended to be provided only for persons with disabilities severe enough to be generally considered as total or near-total disabilities into one in which benefits are also provided for partial disabilities. Thus, while the expressed intent of the House bill is to remove disincentives for severely disabled persons to seek independence through employment, its result could well be to increase dependency among less severely disabled individuals.

At the same time, the committee is convinced that ways can be found to remedy the work disincentive features of the disability programs without incurring the risks which seem to be inherent in the approach suggested by the House bill.

Committee bill.—Other sections of this bill include provisions which are aimed at responding to the work disincentive issues raised by current law in both the DI and SSI programs. These include provisions for extending the present trial work period from 9 months to 24 months, the exclusion of impairment-related work expenses in determining whether an individual is performing SGA, and for the authorization of experimental and demonstration projects by the Social Security Administration.

In addition, the committee bill includes an amendment, which, on a demonstration basis, provides that a disabled individual who loses his eligibility for regular SSI benefits because of performance of SGA would become eligible for a special benefit status which would entitle him to cash benefits equivalent to those he would be entitled to receive under the regular SSI program. Persons who receive these special benefits would be eligible for medicaid and social services on the same basis as regular SSI recipients. States would have the option of supplementing the special Federal benefits. When the individual's earnings exceeded the amount which would cause the cash benefit to be reduced to zero ($481 at the present time), the special benefit status would be terminated and the individual would not thereafter be eligible for any benefits under the program unless he could again establish his eligibility for SSI under the rules of existing law. Even though the individual would in said circumstances lose his special benefit status

for purposes of cash payments, he could retain eligibility for medicaid and social services, if the Secretary found (1) that termination of eligibility for these benefits would seriously inhibit the individual's ability to cotinue his employment, and (2) the individual's earnings were not sufficient to allow him to provide for himself a reasonable equivalent of the cash and other benefits that would be available to him in the absence of earnings. This provision allowing continuation of eligibility for medicaid and social services for persons whose earnings make them ineligible for cash benefits would also apply to SSI recipients who are blind. The committee provision would be limited to three years, to give the committee the opportunity to review the effectiveness of the provision. A provision is included in the committee amendment requiring the Social Security Administration to provide for separate accounting of any funds spent under the provision. This will enable both the Administration and the committee to evaluate the magnitude and the effect of the provision. Separate identification of these benefits would also serve to emphasize the intent that the provision not be administered as a change in the overall definition of disability.

The committee is convinced that the amendments it has recommended in this bill represent a very substantial answer to the problem of work disincentives for the severely disabled. At the same time, the committee emphasizes that the provisions of this bill are carefully designed to avoid unintended and undesirable results. The bill makes no change in the basic definition of disability nor in the way that definition is applied in determining initial eligibility. Thus, there can be no possibility that the bill will result in adding less severely disabled individuals to the benefit rolls.

The provision is effective only for the period July 1, 1980 through June 30, 1983. This will allow ample time to assess the success of the new provisions in reducing work disincentives and to consider any problems of administration which may arise.

TREATMENT OF EARNINGS IN SHELTERED WORKSHOPS

(Section 202 of the Bill)

Present law.—Under current interpretations, income received by an SSI recipient who is in a sheltered workshop as part of a rehabilitation program is not considered to be wages and is therefore treated as unearned income. As a result, all remuneration in excess of $20 a month reduces the SSI benefit on a dollar-for-dollar basis. In contrast, income of a recipient in a sheltered workshop who is not in a rehabilitation program is treated as earned income, and the individual is entitled to the earned income disregards ($65 per month plus one-half of additional earnings). It is estimated by the Department of Health, Education, and Welfare that there are approximately 5,000 individuals now in sheltered workshops who are not able to get the benefit of the earned income disregard provisions.

Committee bill.—The committee believes that participation by SSI recipients in vocational rehabilitation programs should be encouraged and that individuals who participate in sheltered employment as part of a rehabilitation program should be eligible for the work incentive features of the earned income disregards in the SSI law. The commit-

tee amendment would eliminate the present discriminatory treatment of these disabled individuals by providing that income received by SSI recipients as remuneration for participation in sheltered workshops be treated as earned income in all cases.

TERMINATION OF ATTRIBUTION OF PARENTS' INCOME AND RESOURCES WHEN DISABLED CHILD RECIPIENT OF BENEFITS ATTAINS AGE 18

(Section 203 of the Bill)

Present law.—For purposes of the SSI program, the term "child" is defined to include an individual age 18 through 21 who is a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him for gainful employment. Otherwise, all persons age 18 or over are treated as adults. The effect of the present definition, in combination with the provision requiring that the parents' income and resources must be deemed to a child under age 21 in determining the child's eligibility for SSI, may be to discourage a disabled individual between the ages of 18 and 21 from attending school or training. By attending school the individual must be considered a "child" under the SSI law, and the parents' income and resources are deemed to him. The result may be that he loses his SSI eligibility, or that the amount of the benefit is greatly reduced. By not attending school the individual is not considered a child, and only his own income and resources are countable for purposes of determining SSI eligibility.

Committee bill.—The committee believes that there is no logical basis for making this distinction between students and nonstudents for purposes of SSI eligibility, and that because of its potentially negative effects on incentives of disabled individuals for education and training, the provision of present law should be changed. Thus the committee bill would, in effect, eliminate any differential treatment of individuals on the basis of student status. Those individuals who on the effective date of the provision are age 18 and over and who are receiving benefits would be protected against any potential loss of benefits under a "grandfather" provision in the committee bill.

The committee provision should not affect significant numbers of SSI recipients. In June 1976 there were only about 18,000 individuals between the ages of 18 and 22 who were receiving SSI benefits, and many of these would not in any case be attending school. The committee expects that for some, however, the change in law will increase the likelihood of school attendance and that the provision will encourage disabled individuals to become self-sustaining.

D. Provisions Affecting Disability Recipients Under OASDI and SSI Programs

CONTINUED PAYMENT OF BENEFITS TO INDIVIDUALS UNDER VOCATIONAL REHABILITATION PLANS

(Section 301 of the Bill)

Present law.—The 1965 social security amendments gave the Department of Health, Education, and Welfare the authority to use certain social security trust funds to reimburse State vocational rehabilitation

agencies for the cost of services provided to disability insurance beneficiaries. The amendments required the Secretary of HEW to develop criteria for selecting individuals to receive rehabilitation services under the beneficiary rehabilitation program. The criteria were to be based on the savings which would accrue to the trust funds as a result of rehabilitating the maximum number of individuals into productive activity. If the State rehabilitation agency certifies that a beneficiary meets these criteria, the cost of the rehabilitation services is borne by the trust funds.

The Department has developed four criteria for selecting beneficiaries to receive services financed from the trust fund. These are:

1. The disabling physical or mental impairment is not so rapidly progressive as to outrun the effect of vocational rehabilitation services or to preclude restoration of the beneficiary to productive activity.

2. The disability without the services planned is expected to remain at a level of severity resulting in the continuing payment of disability benefits.

3. A reasonable expectation exists that providing such services will result in restoring the individual to productive activity.

4. The predictable period of productive work is long enough that the benefits which would be saved and the contributions which would be paid to the trust funds from future earnings would offset the costs of planned services.

The title XVI legislation enacted in 1972 authorized the referral of blind and disabled recipients under the SSI program for rehabilitation services provided by State vocational rehabilitation programs. The legislation also authorized the use of general revenues to reimburse the State agencies for the cost of services provided to SSI recipients. Both the House and Senate reports on the SSI legislation state:

> Many blind and disabled individuals want to work and, if the opportunity for rehabilitation for suitable work were available to them they could become self-supporting.

In developing the SSI-vocational rehabilitation program, the Department of HEW followed the pattern of the disability beneficiary rehabilitation program for title II beneficiaries. Regulations implementing the program state that its purpose is:

> * * * to enable the maximum number of recipients to increase their employment capacity to the extent that * * * full-time employment, part-time employment, or self-employment wherein the nature of the work activity performed, the earnings received, or both, or the capacity to engage in such employment or self-employment, can reasonably be expected to result in termination of eligibility for supplemental security income payments, or at least a substantial reduction of such payments * * *.

In keeping with this statement of purpose, the SSI program uses the same four criteria for selecting individuals to receive reimbursed services as are used for selecting individuals under the DI program.

Under present law, persons who are participating in a vocational rehabilitation program are eligible for disability benefits only so long as they continue to meet the definition of disability for the DI and

SSI programs. Even in cases where continuation in a VR program might substantially improve an individual's chances of permanent productive employment, his disability benefits are ended when he is determined to have medically recovered, and as a result he may be forced to discontinue his participation in a rehabilitation program.

Committee bill.—The committee recognizes that a person's physical or mental impairment may sometimes improve to the extent that he may no longer meet the strict criteria required to be eligible for cash benefits, yet not to the extent that would constitute full recovery. In such situations, completion of a vocational rehabilitation program may make a significant difference in the ultimate degree of recovery and the level of productivity and self-sufficiency achieved by the disabled person. The committee bill would amend both the DI and the SSI statutes to provide that benefits under these programs shall not be terminated or suspended because the physicial or mental impairment on which the individual's entitlement to benefits is based has or may have ceased if (1) the individual is participating in an approved vocational rehabilitation program under a State plan approved under title I of the Rehabilitation Act of 1973, and (2) the Secretary of HEW determines that the completion of the program, or its continuation for a specified period of time, will increase the likelihood that the individual may be permanently removed from the disability rolls. The committee expects that in most cases medical cessation of disability will result in the termination of benefits, as occurs now in all cases. The committee provision is intended to take into account those exceptional cases where the administration is able to determine that continuation in a vocational rehabiltation program will increase the likelihood of the individual's being permanently removed from the disabilty rolls.

DEDUCTION OF IMPAIRMENT-RELATED WORK EXPENSES IN DETERMINING SGA

(Section 302 of the Bill)

Present law.—Regulations issued under present law provide that in determining whether an individual is performing SGA, extraordinary expenses incurred by the individual in connection with his employment and because of his impairment are to be deducted to the extent that such expenses exceed what his expenses would be if he were not impaired. Regulations specify that expenses for medication or equipment which the individual requires to enable him to carry out his normal daily functions may not be considered work related, and may not be deducted even if they are also essential to the individual's employment.

Committee bill.—For purposes of both the disability insurance and supplemental security income programs, the committee bill would permit a deduction of costs of extraordinary impairment-related work expenses, attendant care costs, and the cost of medical devices, equipment, and drugs and services (necessary to control an impairment) from earnings for purposes of determining whether an individual is engaging in substantial gainful activity regardless of whether these items are also needed to enable him to carry out his normal daily functions. In addition, the bill provides that the deduction would apply where the disabled individual does not pay the cost of the impairment-

related work expenses (i.e., when the cost is paid by a third party), and adds language giving the Secretary the authority to specify in regulations the type of care, services, and items that may be considered necessary to enable a disabled person to engage in SGA. The amount of earnings to be excluded will be subject to such reasonable limits as the Secretary may prescribe. The committee intends that any such limits not be based on arbitrary conceptions of what amounts are reasonable but rather reflect actual prevailing costs of various categories of impairment-related expenses. Also, since the provision is meant to permit persons with impairment-related work expenses to continue to receive disability benefits even when they have earnings above the SGA level, the committee understands that "services" (the nature and value of the work) generally will not be the basis for determining that an individual has demonstrated an ability to engage in SGA if earnings after deducting allowable work expenses are below the SGA level.

EXTENSION OF THE TRIAL WORK PERIOD

(Section 303 of the Bill)

Present law.—Under present law, when an individual completes a 9-month trial work period, and then in a subsequent month performs work constituting substantial gainful activity (SGA), his benefits are terminated. He obtains benefits for the first month in which he performs SGA (after the trial work period has ended) and for the 2 months immediately following.

The committee is concerned that the present 9-month trial work period is insufficient as an incentive for disabled people to return to work, and wants this situation corrected. The abruptness of the termination of the trial work period forces people who work for some time and then, because of their impairment, must stop work, to refile an application and go through the lengthy determination process again. The committee believes the possibility of having to go through this process again poses a sizable impediment to disabled beneficiaries contemplating a return to work.

Committee bill.—For purposes of the DI program, the committee provision would extend the present 9-month trial work period to 24 months for both DI and SSI recipients. In the last 12 month of the 24-month period the individual would not receive cash benefits while engaging in substantial work activity, but could automatically be reinstated to active benefit status if a work attempt fails. The provision also provides that the same trial work period would be applicable to disabled widows, and widowers (who are not permitted a trial work period at all under existing law). The bill does not alter the aspect of present law in which benefits are paid for the month SGA is achieved and the 2 subsequent months, after a successful completion of the 9-month trial work period.

In addition the provision does not change the aspect of present law that a disability ceases if the individual no longer suffers from a severe impairment.

DISABILITY DETERMINATIONS; FEDERAL REVIEW OF STATE AGENCY DETERMINATIONS

(Section 304 of the Bill)

Present law.—The States and the Social Security Administration jointly administer the DI and SSI disability programs. The major responsibility for making disability determinations rests with the State agencies. SSA is responsible for setting administrative policy and for conducting oversight.

Until 1972 the Social Security Administration reviewed a majority of State allowances before they were actually made, thus providing preadjudicative review in most cases. As the result of pressures to reduce costs and staff levels, as well as to meet the pressures of a growing workload, SSA moved to a sample review procedure which involved only 5 percent of allowances. Moreover, these reviews have been made on a postadjudicative basis, that is, after the claimant has already been awarded his disability benefit. Similar sample reviews have been set up at the reconsideration and hearing stages of the process, and for the continuing disability review process.

The State agencies were confronted with very heavy workload increases in the first half of the 1970's, and particularly after the implementation of the SSI program. There is no question that in the minds of many administrators at both the Federal (SSA) and State agency levels the priority in this period was to be speed. Significant backlogs were accumulating at various places and various stages of the claims process, and it was considered important to expedite the process. Many now feel that the result was a decline in the quality of decisions which were being made.

One of the major criticisms that has been made by the existing determination process is that there is not uniformity of decisions and that different State agencies have been making decisions using different criteria. The assumption, thus, is that it is easier (or more difficult) to meet the disability definition depending on where you live.

As can be seen from the table that follows, State allowance rates vary substantially. In fiscal year 1978 initial disabled worker allowances ranged from 53.1 percent in New Jersey to 22.2 percent in Alabama.

TABLE 17. INITIAL DISABLED WORKER ALLOWANCES AS PERCENT OF INITIAL DISABLED WORKER DETERMINATIONS—HIGH AND LOW STATES

Fiscal Year 1978

High third		*Low third*	
State:	*Rate*	State:	*Rate*
New Jersey	53.1	Alabama	22.2
Nebraska	52.1	New Mexico	22.4
Kansas	49.0	Louisiana	30.6
Wisconsin	48.6	Connecticut	32.4
Utah	48.4	Maryland	32.6
Iowa	47.9	Alaska	32.7
Delaware	47.6	Mississippi	34.1
Colorado	47.5	Arkansas	34.3
Vermont	46.5	Puerto Rico	35.2
Ohio	46.0	New York	35.3
South Dakota	45.7	Washington	35.3
Missouri	45.3	Michigan	35.4
Massachusetts	44.0	California	35.4
Maine	43.9	Idaho	35.8
North Carolina	43.6	Oregon	35.8
Nevada	43.6	Tennessee	36.0
Montana	43.3	New Hampshire	36.8
		Wyoming	36.8

Source: Social Security Administration.

Similarly, variations in allowance and denial rates occur at later stages of adjudication as well. The SSA administrative law judges (ALJ's) have frequently been criticized not only for their variations in productivity, but also for their variations in reversal rates. A person who requests a hearing may be assigned to what have been referred to as either "easy" or "hanging" judges. In the period January—March 1979, 33 percent of ALJs awarded claims to from zero to 46 percent of the disabled workers whose cases they decided, 46 percent of ALJs awarded claims to from 46 to 65 percent, and 21 percent of ALJs awarded claims to from 65 to 100 percent. Overall, the percentage of hearings that result in a reversal (an allowance of benefits) has been increasing. In fiscal year 1969 the title II disability reversal rate was 39 percent. It increased to 46 percent in 1973, and by 1978 had actually increased to more than half, or 52 percent of all cases. The SSI hearing reversal rate has increased from 42 percent in fiscal year 1975 to 47 percent in 1978.

The committee is concerned about these State-to-State, ALJ-to-ALJ variations and about the high rate of reversal of denials which occurs at various stages of adjudication, for it indicates that possibly different standards and rules for disability determinations are being used at the different locations and stages of adjudication.

DISABILITY ADJUDICATION PROCESS

[Calendar year 1978]

Level of decision	Number of decisions [1]	Allowances	Denials	Reversal rate
Initial decisions, total (including district office)	1,190,000	357,000	[2] 833,000	(70% denial rate)[2]
Initial decisions made by State agencies	905,000	357,000	548,000	(61% denial rate)
Reconsiderations	228,600	45,600	183,000	20%.
ALJ hearings	87,800	44,800	43,000	51%.
Appeals council	21,600	900	20,700	4%.
Federal courts	4,900	[3] 1,600	3,300	33%.[4]

[1] Includes all title II disability decisions—disabled worker, disabled widow(er)s and adults disabled in childhood.

[2] Includes all denials, made both by Social Security district offices and State disability agencies. 285,000 of these denials are technical denials (involving primarily lack of insured status) and do not require a determination of disability by a State agency.

[3] Includes 1,260 remands and 340 court allowances.

[4] Includes remands from Federal courts.

Source: Data provided by the Social Security Administration.

Committee bill.—The committee believes that while the Federal-State determination system generally works reasonably well (many State agencies do an excellent job), significant improvements in Federal management and control over State performance are necessary to ensure uniform treatment of all claimants and to improve the quality of decisionmaking under the Nation's largest Federal disability programs.

In order to strengthen Federal management, the committee provision would eliminate the current system of negotiated agreements between the Federal Government and the States, which gives the Secretary of Health, Education, and Welfare only general authority over the program, and which leaves great discretion to the States as to how the disability determination process is to be carried out. The bill would give the Secretary the authority to establish, through regulations, the procedures and performance standards for the State disability determination procedures. While regulations might specify, for example, administrative structure, the physical location of and relationship among agency staff units, the emphasis is expected to be on performance criteria, fiscal control procedures, and other rules designed to assure equity and uniformity in State agency disability determinations.

States would have the option of administering the program in compliance with these standards or turning over administration to the Federal Government. If a State wishes to make disability determinations with respect to only a portion of the applicant population, the committee bill would give the Secretary the discretion to agree to such an arrangement under such conditions as he determines to be appropriate. States that decide to administer the program must comply with standards set by the Secretary subject to termination by the Secretary if the State substantially fails to comply with the regulations and written guidelines.

The committee believes that this new Federal administrative authority will both improve the quality of determinations and ensure that claimants throughout the Nation will be judged under the same uniform standards and procedures, while preserving the basic Federal-State structure.

If a State elects not to continue administration or the Secretary terminates a State's administration because of substantial failure to comply with regulations, it is essential that there be adequate procedures to establish Federal administration. Two issues are of particular concern: the position of the State employees involved, and the potential disruption of the ongoing determination process which could create hardships for disability applicants.

Although the committee does not expect any widespread departure from traditional State administration of the disability determination process, it is prudent to prepare for this contingency. Even though under existing law States have the power to terminate agreements, the Department of HEW appears not to have done any extensive planning for Federal administration of State operations.

Thus, to stimulate Department planning and to inform the Congress as to what problems would be presented and possible means of alleviating them the provisions would require the Secretary to submit to the Congress, no later than July 1, 1980, a detailed plan on how

he expects to assume the functions and operations of a State disability determination unit should it become necessary. The bill further states that such a plan should assume the uninterrupted operation of the disability determination process, including the utilization of the best qualified personnel to carry out this function.

The provision also requires that recommendations for any amendments of Federal law or regulations required to carry out the plan should be submitted with the report.

In further response to concerns about the uniformity of decisions, the committee provision would have the effect, over time, of reinstituting the review procedure used by SSA until 1972. The committee provision provides for preadjudicative Federal review of at least 15 percent of allowances and denials in fiscal year 1981, 35 percent in 1982, and 65 percent in years thereafter. The requirement of reviewing at least a fixed percentage overall does not mean that this same percentage would apply in every State, nor every stage of adjudication; the committee would expect that the Social Security Administration will review a relatively higher or lower percentage of determinations where this is merited. The requirement that this percentage of reviews be made prior to effectuation of the decision is not intended to preclude other reviews the Secretary may find appropriate either before or after effectuation nor actions he may take as a result of such other reviews.

Under the committee bill, the Secretary would have the authority to revise State agency decisions that are unfavorable to the claimant. Under present law, the Secretary is permitted only to revise favorable decisions of disability or establish a later date of onset of disability.

Although the language of the bill pertains only to the DI program, the committee expects that the review procedures implemented by SSA will be applied equally to both the DI and SSI programs, since the disability determination is, for the most part, the same for both programs. However, the specific percentage goals would have to be met only for the title II program.

INFORMATION TO ACCOMPANY SECRETARY'S DECISIONS AS TO CLAIMANT'S RIGHTS

(Section 305 of the Bill)

Present law.—Notices to claimants regarding the Secretary's decision on their claim for disability benefits provide little guidance as to the causes for a denial.

Complaints about the content of denial notices have been voiced for a long time. It is felt that the brief form letter which constitutes the notice does not provide the individual who has been denied benefits with enough of the particulars of his case to provide assurance that his case has been decided fairly.

Committee bill.—The committee provision would require that notices be provided to denied claimants expressed in language understandable to the claimant, which include a discussion of the evidence of record and the reasons why the disability claim is denied. This will add a number of positive factors to the adjudication process. The State agency decision will be on a sounder base because the examiner

will be required to formulate the reasons for his decision in written form and the claimant may be less likely to appeal the decision if he understands how the law relates to his particular case.

It is not the intent of the committee that the denial notification be a voluminous document. Further, the statement of the case should not include matters the disclosure of which (as indicated by the source of the information involved) would be harmful to the claimant, but if there is any such matter, it may be disclosed to the claimant's representative unless the latter's relationship with the claimant is such that disclosure would be as harmful as if made to the claimant.

LIMIT ON PROSPECTIVE EFFECT OF APPLICATION

(Section 306 of the Bill)

Present law.—Present law provides that if an applicant satisfies the requirements for benefits at any time before a final decision of the Secretary is made, the application is deemed to be filed in the first month for which the requirements are met. One consequence of this provision is that the claimant is afforded a continuing opportunity to establish eligibility until all levels of administrative review have been exhausted, i.e., until there is a final decision. Thus, a claimant can continue to introduce new evidence at each step of the appeals process, even if it refers to the worsening of a condition or to a new condition that did not exist at the time of the initial application. This is frequently referred to as the "floating application" process.

Committee bill.—The committee bill provides for foreclosing the introduction of new evidence with respect to a previously filed application after the decision is made at the administrative law judge (ALJ) hearing, but would not affect remand authority to remedy an insufficiently documented case or other defect. The committee bill makes this change on a statutory basis only in title II inasmuch as title XVI, unlike title II, does not specify the period of validity for an application but leaves that matter to be determined through regulations. Since the two programs are administered jointly, however, the committee would expect the same rule to be followed in both SSI and DI.

The committee further understands that SSA plans to experiment with the use of an SSA representative to present and defend the reconsideration decision at the hearing. The committee has been told that this new proceeding will create greater uniformity and consistency in administrative law judge (ALJ) decisions and will result in faster, better decisions. It also will ensure that the ALJ is restricted to a judgmental role. At present, the ALJ must conduct the Government's case, assist the claimant, and then decide the outcome of the appeal.

The committee supports SSA's plans to test this approach. It understands that these hearings will be conducted in compliance with the Administrative Procedure Act.

The committee anticipates that the administration would provide the committee with full information on the results of the experiment, including the potential effects on administrative and benefit expenditures, before any decision is made to implement the new "adversary proceeding" nationally.

MODIFICATION OF SCOPE OF FEDERAL COURT REVIEW AND LIMITATION OF COURT REMANDS

(Section 307 of the Bill)

Present law.—Review of a case by the Appeals Council of the Office of Hearings and Appeals is the final recourse a claimant has within the administrative review process of the Social Security Administration if he is dissatisfied with the disposition of his case. However, increasing reversal of the Agency's final decision is being pursued in a U.S. district court.

The number of appeals filed with Federal district courts has grown dramatically in the last decade. As is the situation of the workload of the Office of Hearings and Appeals, the vast majority of the court cases involve disability. Between 1955 and 1970, the number of disability appeals filed with Federal district courts totaled slightly under 10,000 cases for the entire period. Currently, there are approximately 15,000 DI and SSI disability cases pending in the Federal court system.

The statutory base underpinning the scope of judicial review of determinations made by the Agency is found in section 205(g) of the Social Security Act:

> The Court shall have power to enter, upon the pleadings, and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a hearing. The findings of the Secretary as to any fact, *if supported by substantial evidence*, shall be conclusive, * * * (emphasis supplied)

In theory, the "substantial evidence rule" imposed on the courts contrasts the review at that level with those conducted within the administrative process of the Social Security Administration in which cases are reviewed "de novo." Complaints have long been made by the Social SecurityAdministration and others that the courts have frequently by-passed the substantial evidence rule by substituting their judgment of the facts for those of agency adjudicators.

In addition to concern about the growth of the courts' workloads and adherence to the substantial evidence rule, concern has been expressed about the Secretary's authority, on his own motion, to remand a case back to an ALJ prior to filing his answer in a court case.

Some critics have suggested that such absolute discretion gives the Secretary potential authority to remand cases back so that they can be strengthened to sustain court scrutiny. Others have suggested that such a device also may have the tendency to lead to laxity in appeals council review in that it will give the council another look at the case if the claimant decides to go to court.

Similarly, under existing law the court itself, on its own motion or on motion of the claimant, has discretionary authority "for good cause" to remand the case back to the ALJ. It would appear that, although many of these court remands are justified, some remands are undertaken because the judge disagrees with the outcome of the case even though he would have to sustain it under the "substantial evidence rule." Moreover, the number of these court remands seems to be increasing.

Committee bill.—The committee provision would modify the scope of Federal court review so that the Secretary's determinations with respect to facts would be final, unless found to be arbitrary and capricious. The committee intends that the courts should apply this test strictly and not use it as a means of substituting the judgment of the court for the judgment of an administrative law judge as to evidentiary adequacy. The substantial evidence requirement would be deleted. This would apply to decisions under both the OASDI and SSI programs. The committee provision also would eliminate the provision in present law which requires that cases which have been appealed to the district court be remanded by the court to the Secretary upon motion by the Secretary. Instead, remand requested by the Secretary would be discretionary with the court, and only on motions of the Secretary where "good cause" was shown. The bill would continue the provision of present law which gives the court discretionary authority to remand cases to the Secretary, but adds the requirement that remand for the purpose of taking new evidence be limited to cases in which there is a showing that there is new evidence which is material and that there was good cause for failure to incorporate it into the record in a prior proceeding.

TIME LIMITATIONS FOR DECISIONS ON BENEFIT CLAIMS

(Section 308 of the Bill)

Present law.—Under present law and regulations there is no limit on the time taken by the Social Security Administration to adjudicate cases at any stage of adjudication. Several Federal district courts have imposed such limits at the hearing level and numerous bills have been introduced to set such limits at various levels of adjudication.

Committee bill.—The committee provision requires the Secretary of HEW to submit a report to Congress no later than July 1, 1980, recommending appropriate time limits for the various levels of adjudication.

The provision requires the Secretary in recommending the limits to give adequate consideration to both speed and quality of adjudication. The Secretary's recommendations also should reflect the requirement added by this bill for Federal review of State allowances and denials. Congress could then evaluate the recommendations for consistency with the elements it wishes to emphasize and, if needed, take further action next year.

PAYMENT FOR EXISTING MEDICAL EVIDENCE

(Section 309 of the Bill)

Present law.—Under present law, authority does not exist to pay physicians and other potential sources of medical evidence for medical information already in existence when a claimant files an application for disability insurance benefits. Such authority does exist in the SSI program.

The committee believes that information needed to adjudicate cases could be obtained more expeditiously, and possibly avoid the need for further medical consultative examinations, if existing potential suppliers of information could be reimbursed for making their information available.

Committee bill.—The committee bill provides that any non-Federal hospital, clinic, laboratory, or other provider of medical services, or physician not in the employment of the Federal Government, which supplies medical evidence requested and required by the Secretary for making determinations of disability, shall be entitled to payment from the Secretary for the reasonable cost of providing such evidence.

PAYMENT OF CERTAIN TRAVEL EXPENSES

(Section 310 of the Bill)

Present law.—Under present law, explicit authority does not exist under the Social Security Act to make payments from the trust funds, to individuals to cover travel expenses incident to medical examinations requested by the Secretary in connection with disability determinations, and to applicants, their representatives, and any reasonably necessary witnesses for travel expenses incurred to attend reconsideration interviews and proceedings before administrative law judges. Such authority now is being provided annually under appropriation acts.

Committee bill.—The committee bill provides permanent authority for payment of the travel expenses of individuals (and their representatives in the case of reconsideration and ALJ hearings) resulting from participation in various phases of the adjudication process.

PERIODIC REVIEW OF DISABILITY DETERMINATIONS

(Section 311 of the Bill)

Present law.—Under present administrative practices the State agency not only has the function of deciding who comes on the disability rolls, it must also make determinations as to whether individuals stay on the rolls.

There is, however, no requirement for periodic redetermination of disability for all or even a sizable proportion of persons who are receiving disability benefits. The Social Security claims manual instructs State agencies on certain kinds of cases that are to be selected for investigation of continuing entitlement to disability benefits by means of a medical diary procedure. The agencies are cautioned that most allowed cases involve chronic, static, or progressive impairments subject to little or no medical improvement. In others, the manual further states that even though some improvement may be expected, "the likelihood of finding objective medical evidence of 'recovery' has been shown by case experience to be so remote as not to justify establishing a medical reexamination diary." In general, according to the claims manual, case are to be "diaried" for medical reexamination only if the impairment is one of 13 specifically listed impairments.

The high degree of selectivity used in designating cases for medical reexamination is illustrated by the following statistics for title II. In 1977, there were about 2.7 million disabled workers in current pay status. The number of continuing disability investigations (CDIs) in that year for disabled workers was only about 165,000. Numerous critics, including many within the Social Security Administration, believe that the highly selective diary criteria and other continuing

review procedures are inadequate and result in the continued payment of benefits to many persons who have medically or otherwise recovered from their disability.

Committee bill.—The committee provision provides that there will be a review of the status of disabled beneficiaries whose disability has not been determined to be permanent at least once every three years. This review is not intended to supplant the existing reviews of eligibility that are already being conducted such as those under the current "diary" procedures. Moreover, the committee expects that even cases where the initial prognosis shows the probability that the condition will be permanent will be subject to periodic review, although not necessarily every three years in selective circumstances. The committee believes that such procedures should be applied on the same basis to the DI and SSI programs.

E. Provisions Relating to AFDC and Child Support Programs

AFDC WORK REQUIREMENT

(Section 401 of the Bill)

Present law.—Adult members of AFDC families who are capable of employment are required to register for participation in the work incentive (WIN) program established under title IV–C and to accept training or employment offered through that program. Federal funding for the WIN program, including the costs of necessary supportive services, is provided at a 90-percent matching rate. This program is subject to annual appropriations and is presently funded at a level of $365 million.

The work incentive program was originally enacted by Congress in 1967 with the purpose of reducing welfare dependency through the provision of manpower training and job placement services. In 1971 the Congress adopted amendments aimed at strengthening the administrative framework of the program and at placing greater emphasis on immediate employment instead of institutional training, thus specifically directing the program to assist individuals in the transition from welfare to work.

The 1971 amendments required that all persons at least 16 years of age and receiving AFDC benefits must register for WIN, unless caretaker of a child under age, legally exempt by reason of health, disability, needed in the home, advanced age, student status, or geographic location. Registrants selected for participation in WIN must accept available jobs, training, or needed services to prepare them for employment. Refusal to do so without good cause will result in termination of their AFDC payments.

Since these amendments were enacted, there has been a significant increase in the number of persons placed in employment with resultant savings in AFDC funding. In fiscal year 1976, 158,000 WIN registrants entered employment. Of these, 87,000 individuals, plus the children of these individuals, went off of welfare completely as a result of sufficiently high earnings. In fiscal year 1978, 235,000 WIN registrants entered employment, an increase of 49 percent over 1976, with 136,200 of these individuals and their families going off welfare, an increase of 30 percent over 1976. The table below provides additional data on the WIN program.

TABLE 18.—WORK INCENTIVE PROGRAM DATA, FISCAL YEARS 1971–78

Category	1971	1972	1973	1974	1975	1976	1977	1978
Registrations: in year		120,539	1,235,048	820,126	839,408	942,260	1,060,739	1,013,247
Entered employment:								
Full time	50,444	60,310	136,783	177,271	170,641	211,185	245,566	254,191
Part time						19,680	31,988	39,399
Welfare cost savings (millions)				$129.3	[1] $212.4	[1] $297.0	Over $400	600
Program expenditures (millions):								
Total					$276.7	$303.7	$376	$364
Employment service					205.9	196.2	258	247
Welfare agency					70.8	107.6	117	117

[1] Calendar year data.

Source: U.S. Department of Labor.

Committee bill.—Despite growing success in placing AFDC recipients in employment, the committee believes that the present statutory requirements should be strengthened in such a way as to provide additional encouragement for welfare recipients to move into employment. The committee further believes that AFDC recipients who are able to work should be required to actively seek employment and that this should be made explicit in the law. The committee amendment therefore would amend title IV–A to provide that AFDC recipients who are not excluded from WIN registration by law will be required, as a condition of continuing eligibility for AFDC, to participate in the full range of employment-related activities which are part of the WIN program, including employment search activities. The Employment and Training Administration of the Labor Department estimates that if States elected to use employment search as a primary activity, over 200,000 WIN registrants could participate in such activities and that 31 percent would be retained in employment. The committee anticipates that with such an employment search requirement, substantial numbers of AFDC recipients will find jobs and welfare costs will be reduced.

The employment search mandated by the committee amendment is not to be mechanically applied to require every individual to make a specific number of employment contacts. Rather, the term is to be interpreted to mean those activities determined by the State agency to be appropriate for WIN registrants to undertake to actively seek employment. Employment search activities are intended to be supported by necessary services. Thus the amendment would require the provision of such social and supportive services as are necessary to enable the individual actively to engage in activities related to finding employment and, for a period thereafter, as are necessary and reasonable to enable him to retain employment. For example, transportation costs which are necessary for employment search would be covered, as would the costs of necessary child care. However, the committee expects the program to be so managed that the need for child care will be minimized.

Under present law State matching for supportive services must be in the form of cash. The committee amendment would make it easier for the State to provide the required 10 percent State matching by allowing matching in the form of inkind goods and services.

The amendment would provide for locating supportive services together with manpower services to the maximum extent feasible, eliminate the requirement for a 60-day counseling period before assistance can be terminated, and authorize the Secretaries of Labor and HEW to establish the period of time during which an individual will not be eligible for assistance in the case of a refusal without good cause to participate in a WIN program or accept employment. The amendment also clarifies the treatment of earned income derived from public service employment, and adds to those excluded from the work registration requirement, individuals who are working at least 30 hours a week.

MATCHING FOR AFDC ANTIFRAUD ACTIVITIES

(Section 402 of the Bill)

Present law.—In fiscal year 1977 States reported 183,190 AFDC cases in which there was a question of fraud sufficient to require in-

vestigation of the facts involved. This was 10 percent above the number reported for 1976. Although data are too sketchy to conclude that there has recently been any significant increase in the incidence of fraud, there has been increasing emphasis by the States on the prevention, deterrence, detection, referral for prosecution, and recovery of overpayments in cases involving questions of fraud. Despite this increased activity on the part of the States, a number of problems have been cited in State efforts to deal with welfare cases involving the question of recipient fraud. The 1977 fiscal year report by the Department of Health, Education, and Welfare on the "Disposition of Public Assistance Cases Involving Questions of Fraud" includes a discussion of comments made by State welfare agencies on trends and developments in antifraud programs during the year. Comments include the observation that the statute of limitations frequently is a cause for the dismissal of cases, which indicate backlogs. It was also noted that better preparation of cases referred to law enforcement agencies results in more prompt indictments and/or convictions. A report for the prior year includes the following analysis of State activities:

> Inadequate staffing is a major problem plaguing the identification of cases which involve an intent to defraud, and those which represent overpayments of illegal receipt of assistance. It also affects the actual gathering of essential information for appropriate preparation of information to prove fraud cases for presentation to prosecuting attorneys. Local law enforcement agencies also suffer from staff shortages, resulting in complaints from some States of inaction by county prosecutors on cases which Welfare Board Officials feel should be prosecuted; of long time lapses between referral by prosecuting officers and action taken on cases due to backlog of all criminal cases; and of prosecutors placing a higher priority on the prosecution of crimes other than welfare fraud because of a lack of prosecutors.

Recently there has been increased emphasis in the Department of Health, Education, and Welfare on activities to curb fraud in welfare programs. The committee endorses this emphasis, and expects that the Department will continue to improve the administration of its programs through more rigorous efforts to limit program abuse. The committee realizes, however, that it is the States that must bear the major burden of conducting antifraud activities. At the present time, they are entitled to Federal matching for antifraud activities as part of their regular administrative expenditures, at a 50-percent matching rate.

An analysis of quality control data shows that over 6 percent of all AFDC cases are fraudulent while 11 percent of the cases in error are nonfraudulent. The fraud cases represent 50 percent of the total dollar errors (AFDC, food stamps and medicaid). The average fraud case has a $281 total dollar error compared to $149 per nonfraud case. It is apparent that concentrating on reducing fraud cases would be of great economic value to the Government.

Committee bill.—The committee believes that the new concern for curbing fraud and abuse in welfare programs which has recently been demonstrated by the administration and by the Department of Health, Education, and Welfare should have the effect of further

encouraging the States to pursue the identification and prosecution of fraud. The committee believes, however, that the States should be given positive assistance to accomplish this. The committee amendment therefore would increase the matching rate to 75 percent for State and local AFDC antifraud activities for costs incurred (1) by the welfare agencies in the establishment and operation of one or more identifiable fraud control units; (2) by attorneys employed by the State or local welfare agencies (but only for the costs identifiable with the AFDC antifraud activities); and (3) by attorneys retained under contract (such as the office of the State attorney).

USE OF IRS TO COLLECT CHILD SUPPORT FOR NON-AFDC FAMILIES

(Section 403 of the Bill)

Present law.—Present law authorizes States to use the Federal income tax mechanism for collecting support payments for families receiving AFDC, if the State has made diligent and reasonable efforts to collect the payments without success and the amount sought is based on noncompliance with a court order for support. States have access to IRS collection procedures only after certification of the amount of the child support obligation by the Secretary of Health, Education, and Welfare, or his designee. There must also be an agreement that the State will reimburse the United States for any costs involved in making the collection. The Secretary of HEW in consultation with the Secretary of Treasury, is authorized to establish by regulation criteria for accepting amounts for collection and for making certification, including imposing limitations on the frequency of making certifications.

This provision for using the IRS in child support collections has been used very sparingly by the States. It is, however, recognized as an integral part of the child support collection process which can be used after other efforts to collect delinquent child support payments have proved ineffective.

Committee bill.—The committee has been informed that a number of States believe their child support programs would be strengthened if the IRS collection procedures which are now available for collections in behalf of families receiving AFDC were also available for families receiving State child support services who have not applied for welfare payments. The committee bill would extend IRS's collection responsibilities to non-AFDC child support enforcement cases, subject to the same certification and other requirements that are now applicable in the case of families receiving AFDC.

SAFEGUARDING INFORMATION

(Section 404 of the Bill)

Present law.—Present law provides in part that State plans under title IV–A (AFDC) include safeguards which prevent disclosure of the name or address of AFDC applicants or recipients to any committee or a legislative body. HEW regulations include Federal, State, or local committees or legislative bodies under this provision. Under

their guidelines, HEW exempts audit committees from this exclusion. Several States, however, do not honor the HEW exemption.

Committee bill.—The committee amendment would modify the law to clarify that any governmental agency (including any legislative body or component or instrumentality thereof) authorized by law to conduct an audit or similar activity in connection with the administration of the AFDC program is not included in the prohibition. The amendment would make similar changes with regard to audits under title XX of the Social Security Act.

FEDERAL MATCHING FOR CHILD SUPPORT DUTIES PERFORMED BY COURT PERSONNEL

(Section 405 of the Bill)

Present law.—The child support and establishment of paternity program, enacted at the end of the 94th Congress as title IV–D of the Social Security Act, mandates aggressive administration at both the Federal and State levels with various incentives for compliance and with penalties for noncompliance. The program includes child support enforcement services for both welfare and nonwelfare families. The child support enforcement program leaves basic responsibility for child support and establishment of paternity to the States, but provides for an active role on the part of the Federal Government in monitoring and evaluating State child support enforcement programs, in providing technical assistance, and, in certain instances, in undertaking to give direct assistance to the States in locating absent parents and obtaining support payments from them.

The legislation creating the child support program requires each State to have a program of child support collection and paternity establishment services for both AFDC and non-AFDC families administered by a single and separate organizational unit within the State under a separate State plan for child support administered separately from other State plans. The States administer the child support program through separate child support agencies, popularly referred to as IV–D agencies. Present law requires that State child support plans provide for entering into cooperative arrangements with appropriate courts and law enforcement officials to assist the child support agency in administering the program. The law specifically requires the entering into of financial arrangements with such courts and officials in order to assure optimum results under the child support program and with respect to any other matters of common concern to the courts and the child support agency. Federal regulations are now written in such a way as to allow States to claim Federal matching for the compensation of district attorneys, attorneys general and similar public attorneys and prosecutors and their staff. However, States may not receive Federal matching for expenditures (including compensation) for or in connection with judges or other court officials making judicial decisions, and other supportive and administrative personnel.

In the first 47 months of the child support program (August 1975 through June 30, 1979), States have reported total collections of over $3.6 billion of which $1.6 billion was for AFDC families and $2.0

billion was for families not on welfare, at a total cost of $1.0 billion or 28 cents per dollar collected.

In the first 47 months of the child support enforcement program, 1,573,000 absent parents were located; there were 970,000 support obligations established; and paternity was established by the courts for 323,000 children.

The heavy impact on the court systems of the cities, counties, and States is apparent from statistics showing the tremendous increase in child support activity in these areas since the program's inception in 1976. In fiscal year 1976, 184,000 parents were located. The number of parents located in fiscal year 1978 was 519,000, an increase of 182 percent in 2 years. In fiscal year 1976, 76,000 support obligations were established. The number of support obligations established in fiscal year 1978 was 350,000, an increase of 361 percent in 2 years. In fiscal year 1976 15,000 paternities were established. The number of paternitie established in fiscal year 1978 was 123,000, an increase of 820 percent in just 2 years.

Table 19 compares the monthly number of child support actions with the number of new AFDC "unwed mother" cases opened each month. It is quite apparent that, except for California, the number of "unwed mother" AFDC cases opened every month far exceeds the child support actions to establish paternity in AFDC cases.

Table 20 compares the number of parents located by the child support program with the number of AFDC cases opened each month. Despite the fact that several large States fall far below the national norm, it is evident that the parent location activity in most States is effectively reducing the backlog of existing AFDC "desertion" cases as well as acting on new cases as they are approved for AFDC benefits.

Table 21 shows the projected backlog of paternity and location cases not yet acted upon by the child support agency because the AFDC worker has not made the required referral action to the child support agency.

Table 22 shows that the average duration in AFDC cases where the AFDC worker has not made the required referral action to the child support agency is 58 months.

The success of the child support program in locating absent parents and having the paternity of children established is gratifying to the committee, although the committee realizes that there is an enormous task still ahead for child support. But even this first push to solve the problems which child support agencies are required to do under present laws has created a tremendous backlog of cases awaiting court action in some States. The committee staff estimates that just in the area of paternity determination by courts there are over 150,000 cases in the courts awaiting action. In the city of Philadelphia, Pa., there are over 30,000 cases for paternity establishment awaiting court action. The committee is concerned that this backlog exists in one of the key elements of the child support program.

Committee bill.—The committee amendment would allow Federal matching for those additional costs of the IV–D program not provided for under current regulations. Matching would cover expenditures (including compensation) for judges or other persons making judicial determinations, and other support and administrative personnel of the courts who perform IV–D functions, but only for those functions spe-

cifically identifiable as IV–D functions. Matching would be paid by the State agency directly to the courts if the State so provided. Current levels of spending in the State for these newly matched activities would have to be maintained. No matching would be available for expenditures incurred before January 1, 1980.

CHILD SUPPORT MANAGEMENT INFORMATION SYSTEM

(Section 406 of the Bill)

Present law.—There is increasing evidence that administration of State welfare programs could be significantly improved if States establish and use computerized information systems in the management and operation of their programs. The committee has approved, as another provision of this bill, an amendment to provide States with increased Federal matching for such systems for use in administering their AFDC programs. That amendment would increase the rate of matching to 90 percent for the costs of developing and implementing AFDC systems and to 75 percent for the costs of operating them. These percentages correspond to the matching that is available to the States for use in their medicaid programs.

At the present time, States and localities that wish to establish and use computerized information systems in the management of their child support programs are eligible to receive 75 percent matching of their expenditures. This is the percentage matching which they receive for all costs of administering the child support program.

Committee bill.—The committee believes that States should be encouraged to develop and use management information systems for all programs in their welfare systems in order to provide better management of their programs and to expedite coordination among programs and across jurisdictions. The committee believes that the child support program is vital to the success of each State's welfare system and improvements in its operation should also be encouraged. The committee bill therefore would provide an incentive to State child support enforcement agencies to develop new systems, to expand or enhance their existing systems, or to utilize model systems developed by HEW's Office of Child Support Enforcement by increasing the rate of matching to 90 percent for the costs of developing and implementing the systems. The cost of operating such systems would continue at the 75 percent matching rate.

Under the amendment, the Office of Child Support Enforcement, Department of Health, Education, and Welfare, would be required, on a continuing basis, to provide technical assistance to the States and would have to approve the State system as a condition of Federal matching. (Continuing review of the State systems would also be required.)

To qualify for HEW approval, the system would have to meet specific requirements, including capacity to account for child support collections and distributions; handle billing, monitoring and enforcement; provide management information; provide for cross-checking with AFDC records; handle interstate activity; provide necessary data for Federal statistical reporting requirements; and assure security against unauthorized access to, or use of, the data in the system.

Such approval would be based on the Secretary's finding that the initial and annually updated advanced automatic data processing document, which each State must have, will, when implemented, generally carry out the objectives of the management system. Such a document would provide for the conduct of, and reflect the results of, requirements analysis studies, contain a description of the proposed management system, indicate the security and interface requirements in the system, describe the projected and expected to be available resource requirements for staff and other needs, contain an implementation plan and backup procedures to handle possible failure, contain a summary of the system in terms of qualitative and quantitative benefits and provide such other information as the Secretary determines under regulation is necessary.

AFDC MANAGEMENT INFORMATION SYSTEM

(Section 407 of the Bill)

Present law.—There is increasing evidence that administration of the AFDC program could be significantly improved if States establish and use computerized information systems in the management of their programs. Such systems have been demonstrated to be helpful in program planning and evaluation. They also make day-to-day operations more efficient, and they are crucial to assuring that eligibility determinations are properly made and that fraud and abuse are discovered on a timely and ongoing basis. Although the merits of such systems are generally recognized, the States have been slow to develop them because of the large initial outlays which are necessary, and because of the ongoing cost of operating them. States may currently receive Federal matching for the systems as an administrative cost, but Federal matching is limited to 50 percent. This is in contrast to the medicaid program, in which 90 percent Federal matching is authorized for the cost of developing and implementing computer systems, and 75 percent for their operation.

Committee bill.—The committee is convinced that the administration of State AFDC programs could be greatly improved through judicious use of modern computerized management information systems. Recipients could be expected to benefit from more expeditious handling of their cases and decreases in processing time; local, State, and Federal Governments—and the taxpayer—could be expected to benefit from a decrease in costs because of a reduction in errors and use of better planning and management techniques.

Thus, the committee amendment would provide an incentive to the States to develop and expand their existing systems by increasing the rate of matching to 90 percent for the costs of developing and implementing the systems and to 75 percent for the costs of operating them, provided the system meets the requirements imposed by the amendment. (The increased matching would be applicable to existing systems if they meet the criteria for approval of new systems.)

Under the committee amendment, the Department of Health, Education, and Welfare would be required, on a continuing basis, to provide technical assistance to the States and would have to approve the State system as a condition of Federal matching. (Continuing review of the State systems would also be required.) To qualify for HEW

approval, the system would have to have at least the following characteristics: (1) ability to provide data concerning all AFDC eligibility factors; (2) capacity for verification of factors with other agencies through identifiable correlation factors such as social security numbers, names, dates of birth, home addresses and mailing addresses (including postal ZIP codes); (3) ability to control and account for the costs, quality and delivery of funds and services furnished to applicants and recipients; (4) capability for notifying child support, food stamp, social service, and medicaid programs of changes in AFDC eligibility or benefit amount; and (5) security against unauthorized access to or use of the data in the system.

In approving systems, the Department would have to assure sufficient compatibility among the other public assistance, medicaid, and social services systems in the States and among the AFDC systems of different jurisdictions to permit periodic screening to determine whether an individual was drawing benefits from more than one jurisdiction and for determination of eligibility and payment pursuant to requirements imposed by other sections of the Social Security Act.

Such approval would be based on the Secretary's finding that the initial and annually updated advanced automatic data processing document, which such State must have, will, when implemented, generally carry out the objectives of the statewide management system. Such a document would provide for the conduct of and reflect the results of requirements analysis studies, contain a description of the proposed statewide management system, indicate the security and interface requirements in the system, describe the projected and expected to be available resource requirements for staff and other needs, include cost-benefit analyses of each alternative management system, data processing services and equipment and a plan showing the basis for both indirect and direct rates to be in effect, contain an implementation plan to handle possible failure of contingencies, and contain a summary of the system in terms of qualitative and quantitative benefits.

EXPENDITURES FOR OPERATION OF STATE PLANS FOR CHILD SUPPORT

(Section 408 of the Bill)

Present law.—Present law requires that the Federal Office of Child Support Enforcement maintain adequate records for both AFDC and non-AFDC families of all amounts collected and disbursed and the costs incurred in collecting and disbursing these amounts and publish periodic reports on the operation of the program in the various States and localities and at national and regional levels. The Office of Child Support Enforcement must also submit an annual report to the Congress on all activities undertaken in the child support program as well as the major problems encountered at Federal, State, or local levels which have delayed or prevented implementation of the child support program.

Present law also provides that the State will maintain for both AFDC and non-AFDC families a full record of collections, disbursements, and expenditures and of all other activities related to its child support programs. An adequate reporting system is required. The committee is aware that some States are delinquent in their

recordkeeping and reporting, and believes that this situation must be corrected.

Committee bill.—The committee has been concerned about the failure of some States to report and account for child support collections for AFDC and non-AFDC families on a reasonable, timely basis. The committee amendment thus would improve State reporting by prohibiting advance payment to the State of the Federal share of administrative expenses for a calendar quarter unless it has submitted a full and complete report of the amount of child support collected and disbursed for the calendar quarter which ended 6 months earlier. The amendment would also allow the Department of Health, Education, and Welfare to reduce the amount of the payments to the State by the Federal share of child support collections made but not reported by the State.

ACCESS TO WAGE INFORMATION FOR CHILD SUPPORT PROGRAMS

(Section 409 of the Bill)

Present law.—Under title IV–D of the Social Security Act, States are required to establish special child support agencies to establish paternity and obtain support for any child who is an applicant for or recipient of AFDC. These State agencies must also provide child support services to non-AFDC families, if they apply for child support services. HEW regulations require the State agencies to establish and to periodically review the amount of the support obligation, using the statutes and legal processes of the State.

Committee bill.—The committee bill would improve the capacity of the child support enforcement agency in the State to acquire accurate wage data by providing authority for States and localities to have access to earnings information in records maintained by the Social Security Administration and State employment security agencies. Such information would be obtained by a search of wage records conducted by the Social Security Administration or the employment security agency to identify the fact and amount of earnings and the identity of the employer in the case of individuals who were parents of the children for whom the child support agency was collecting or enforcing support. The Secretary of Health, Education, and Welfare would be authorized to establish necessary safeguards against improper disclosure of the information.

The committee bill specifically authorizes the Social Security Administration to disclose certain tax return information to State and local child support agencies. The information may be used by them for purposes of the child support enforcement program.

TABLE 19.—CHILD SUPPORT CASES OF "PATERNITY ESTABLISHED" PER MONTH COMPARED TO AFDC "UNWED MOTHER" CASE OPENINGS, JULY TO DECEMBER 1977

State	Child support paternity established cases [1]	AFDC unwed mother cases opened [2]	Paternity established cases as percent of cases opened
Alaska	0	47	0.9
Arizona	24	355	6.7
Arkansas	312	501	62.3
California	1,182	934	126.6
Colorado	95	493	19.2
Connecticut	214	558	38.3
Florida	557	1,664	33.5
Georgia	211	1,232	17.1
Hawaii	61	271	22.3
Idaho	3	84	4.0
Illinois	113	3,327	3.4
Indiana	171	803	21.3
Kansas	43	356	12.2
Kentucky	31	922	3.3
Louisiana	84	1,369	6.2
Maryland	525	1,295	40.5
Massachusetts	102	895	11.3
Michigan	547	1,654	33.1
Minnesota	104	682	15.3
Mississippi	68	624	10.9
Montana	6	149	3.8
Nevada	18	92	19.4
New Hampshire	4	126	2.8
New Jersey	625	2,170	28.8
New Mexico	14	242	5.9
New York	1,335	3,221	41.5
North Carolina	427	1,387	30.8
North Dakota	23	100	23.3
Ohio	192	2,341	8.2
Oklahoma	3	450	.6
Oregon	127	550	23.2
Pennsylvania	401	2,438	16.4
South Dakota	9	116	7.5
Tennessee	423	909	46.5
Texas	18	1,872	1.0

See footnotes at end of table.

TABLE 19.—CHILD SUPPORT CASES OF "PATERNITY ESTABLISHED" PER MONTH COMPARED TO AFDC "UNWED MOTHER" CASE OPENINGS, JULY TO DECEMBER 1977—Con.

State	Child support paternity established cases [1]	AFDC unwed mother cases opened [2]	Paternity established cases as percent of cases opened
Utah	14	127	10.9
Vermont	7	57	13.0
Washington	24	581	4.2
West Virginia	13	317	4.1
Wyoming	2	47	3.4
U.S. total	8,132	35,358	23.0

[1] Office of Child Support Enforcement.
[2] Projected from AFDC quality control estimates.

TABLE 20.—CHILD SUPPORT CASES OF "PARENT LOCATED" PER MONTH COMPARED TO AFDC "DESERTION" CASE OPENINGS, JULY TO DECEMBER 1977

State	Child support parents located cases [1]	AFDC desertion cases opened [2]	Parents located cases as percent of cases opened
Alaska	148	47	315.8
Arizona	630	186	338.7
Arkansas	529	269	196.5
California	4,575	467	979.6
Colorado	752	378	198.8
Connecticut	782	381	205.2
Florida	2,085	789	264.2
Georgia	830	653	127.1
Hawaii	490	178	275.3
Idaho	38	105	36.1
Illinois	1,011	1,634	61.9
Indiana	689	265	259.9
Kansas	528	246	214.6
Kentucky	218	753	29.0
Louisiana	244	547	44.6

See footnotes at end of table.

TABLE 20.—CHILD SUPPORT CASES OF "PARENT LOCATED" PER MONTH COMPARED TO AFDC "DESERTION" CASE OPENINGS, JULY TO DECEMBER 1977—Continued

State	Child support parents located cases [1]	AFDC desertion cases opened [2]	Parents located cases as percent of cases opened
Maine	99	246	40.3
Maryland	1,564	978	159.9
Massachusetts	588	1,016	57.9
Michigan	2,364	1,193	198.1
Minnesota	226	274	82.6
Mississippi	392	281	139.4
Montana	113	84	134.0
Nebraska	92	112	82.4
Nevada	224	26	860.9
New Hampshire	81	144	56.5
New Jersey	2,732	1,669	163.7
New Mexico	247	126	195.6
New York	4,924	3,462	142.2
North Carolina	1,184	659	179.7
North Dakota	77	35	219.0
Ohio	1,349	1,066	126.6
Oklahoma	280	404	69.2
Oregon	1,603	533	300.7
Pennsylvania	593	1,896	31.3
South Dakota	5	98	5.4
Tennessee	398	479	83.2
Texas	865	1,268	68.2
Utah	372	188	197.7
Vermont	25	88	27.8
Washington	851	564	150.9
West Virginia	108	300	35.9
Wyoming	212	21	1,007.9
U.S. total	35,115	24,108	145.6

[1] Office of Child Support Enforcement.
[2] Projected from AFDC quality control data.

TABLE 21.—AFDC CASES IN WHICH AFDC WORKER HAS NOT MADE REQUIRED REFERRAL ACTION TO CHILD SUPPORT AGENCY, JULY–DECEMBER 1977

State	Eligibility factor [1]		
	Unwed mother	Desertion	Separation
Alaska	77	103	0
Arizona	236	169	0
California	10,012	6,808	3,204
Colorado	378	309	240
Connecticut	1,435	512	273
Florida	64	192	0
Georgia	1,221	771	257
Hawaii	281	450	168
Illinois	4,634	3,921	891
Indiana	132	0	88
Iowa	225	187	112
Kansas	377	94	283
Kentucky	660	355	253
Louisiana	1,060	689	106
Maine	64	96	64
Maryland	2,188	978	230
Massachusetts	3,100	1,653	2,480
Michigan	5,694	2,928	976
Minnesota	76	0	76
Mississippi	1,442	370	123
Missouri	3,402	1,492	1,014
Montana	0	38	38
Nebraska	0	0	0
New Hampshire	75	0	0
New Jersey	1,669	1,001	445
New Mexico	60	30	30
New York	17,310	12,694	2,596
North Carolina	2,833	3,305	531
Ohio	8,483	3,059	3,894
Oklahoma	173	0	103
Oregon	751	326	326
Pennsylvania	12,518	7,316	2,438
Rhode Island	251	50	0
South Dakota	0	0	36
Tennessee	694	148	248

[1] Projected from AFDC quality control estimates.

TABLE 21.—AFDC CASES IN WHICH AFDC WORKER HAS NOT MADE REQUIRED REFERRAL ACTION TO CHILD SUPPORT AGENCY, JULY–DECEMBER 1977—Continued

State	Eligibility factor [1]		
	Unwed mother	Desertion	Separation
Texas	226	301	0
Utah	36	36	36
Vermont	152	76	342
Washington	171	273	444
West Virginia	165	41	41
Wyoming	14	14	14
U.S. total	82,339	50,785	22,400

[1] Projected from AFDC quality control estimates.

TABLE 22.—AVERAGE NUMBER OF MONTHS CASE HAS BEEN ON AFDC WHERE THE REQUIRED AFDC REFERRAL TO CHILD SUPPORT AGENCY HAS NOT BEEN MADE, JULY–DECEMBER 1977

	Eligibility factor [1]		
	Unwed mother	Desertion	Separation
Alaska	40	11	0
Arizona	91	37	0
California	62	63	66
Colorado	37	68	45
Connecticut	56	68	88
Florida	16	118	0
Georgia	65	81	82
Hawaii	25	67	48
Illinois	65	51	32
Indiana	72	0	39
Iowa	23	43	121
Kansas	66	53	106
Kentucky	64	53	42
Louisiana	57	65	103
Maine	34	68	73

[1] Projected from AFDC quality control estimates.

TABLE 22.—AVERAGE NUMBER OF MONTHS CASE HAS BEEN ON AFDC WHERE THE REQUIRED AFDC REFERRAL TO CHILD SUPPORT AGENCY HAS NOT BEEN MADE, JULY–DECEMBER 1977—Continued

State	Eligibility factor [1]		
	Unwed mother	Desertion	Separation
Maryland	44	60	25
Massachusetts	44	62	73
Michigan	36	32	25
Minnesota	78	0	76
Mississippi	58	70	57
Missouri	70	62	50
Montana	0	2	11
Nebraska	0	0	0
New Hampshire	6	0	0
New Jersey	39	58	49
New Mexico	44	22	114
New York	64	54	80
North Carolina	47	78	34
Ohio	53	36	38
Oklahoma	94	0	18
Oregon	40	25	67
Pennsylvania	67	69	76
Rhode Island	68	10	0
South Dakota	0	0	1
Tennessee	57	34	51
Texas	121	51	0
Utah	6	3	10
Vermont	68	144	59
Washington	62	100	35
West Virginia	19	21	16
Wyoming	1	62	0
U.S. total	58	58	58

[1] Projected from AFDC quality control estimates.

F. Other Provisions Relating to the Social Security Act

RELATIONSHIP BETWEEN SOCIAL SECURITY AND SSI BENEFITS

(Section 501 of the Bill)

Present law.—A substantial proportion of SSI recipients are also eligible for benefits under the old-age, survivors, and disability insurance program under title II of the Social Security Act. The proportion of dual eligibility can be expected to increase in the future since many of those who are now ineligible for title II benefits are simply so old that their period of work history occurred prior to the time that social security coverage was available. The number of SSI recipients who also receive title II benefits is shown in table 23.

Though the two programs are administered by the same agency, it can sometimes happen that an individual's first check under one program will be delayed. If the SSI check is delayed, retroactive entitlement takes into account the amount of income the individual had from social security. However, if the title II check is delayed, a windfall to the individual can occur since it is not possible to retroactively reduce his SSI benefit beyond the beginning of the current quarter.

Even for the current quarter, court decisions require the Social Security Administration to treat the erroneous SSI payments as overpayments which cannot be collected without first offering the recipient an evidentiary hearing.

Committee bill.—Under the committee provision the statute would be amended to provide that an individual's entitlement under the two titles shall be considered as a totality so that payment under either program shall be deemed to be a payment under the other if that is subsequently found to be appropriate. Thus, if payment under title II is delayed so that a higher payment is made under title XVI, the adjustment made in the case of any individual will only be the net difference in total payment. There would, of course, be the proper accounting adjustments to assure that the appropriate amounts were charged to the general fund and the trust funds respectively. Any appropriate reimbursement would also be made to the States where State supplementary benefits are involved. The committee expects that the Department will ensure that applicants are made aware this adjustment is required by law at the time they file their claims for benefits.

TABLE 23.—NUMBER AND PERCENT OF PERSONS RECEIVING FEDERALLY ADMINISTERED SSI PAYMENTS WHO ALSO RECEIVE SOCIAL SECURITY (OASDI) BENEFITS, BY CATEGORY, SEPTEMBER 1978

Reason for eligibility	Total	With social security benefits	
		Number	Percent of total
Total	4,231,049	2,157,269	52.1
Aged	1,993,212	1,374,887	68.9
Blind and disabled	2,238,311	782,382	34.9

EXTENSION OF THE TERM OF THE NATIONAL COMMISSION ON SOCIAL SECURITY

(Section 502 of the Bill)

Present law.—The National Commission on Social Security was established by the Social Security Amendments of 1977, with its members jointly appointed by the President and Congress, to make a broad-scale, comprehensive study of the social security program, including medicare. The study will include the fiscal status of the trust funds, coverage, adequacy of benefits, possible inequities, alternatives to the current programs and to the method of financing the system, integration of the social security system with private retirement programs, and development of a special price index for the elderly.

Under current law, the terms of its members are to last 2 years, and the Commission itself will expire on January 1, 1981.

Additional time will be needed to closeout the work of the Commission as well as to extend the terms of its members to coincide with the expiration date of the Commission.

Committee bill.—The committee provision would extend for 3 months the expiration date of the National Commission on Social Security and the terms of its members. Under the committee provision, the Commission's work and the terms of its members would end on April 1, 1981.

FREQUENCY OF FICA DEPOSITS FROM STATE AND LOCAL GOVERNMENTS

(Section 503 of the Bill)

Present law.—Effective January 1, 1951, the Social Security Act extended social security coverage to State and local government employees. Coverage is through voluntary agreements between the Secretary of HEW and the individual States. The act provides that the regulations of the Secretary shall be designed to make the deposit requirements imposed on States the same, so far as practicable, as those imposed on private employers.

Each State deposits the combined State and local government social security contributions directly with the Federal Reserve Bank for transfer to the trust funds. As required by regulation, each State deposits contributions and files wage reports of covered employees with HEW within 1 month and 15 days after the end of each calendar quarter. This time frame was requested by the States and has been in effect since 1959. Before 1959, the States were required to file wage reports and make deposits within 30 days after the end of each calendar quarter.

Contributions paid by workers and their State and local government employers increased from about $867,000 in fiscal year 1951 to over $9.8 billion in fiscal year 1977. These contributions are estimated to increase to about $15.7 billion by fiscal year 1980.

On March 30, 1978, the Department published in the Federal Register its proposed rulemaking increasing from quarterly to monthly the frequency with which States must deposit social security contributions on wages and salaries paid to covered employees—the so-called 15–15–15 method.

By allowing the States to make quarterly deposits of State and local contributions, HEW lost about $1.1 billion in interest income to the trust funds from 1961 through 1979.

HEW considered both the oral and written comments on its proposed rules and, as a result, made changes which require that the States deposit the social security contributions for each of the first 2 months of a calendar quarter by the 15th day after each month. The contributions for the third month of the quarter will not be due until 1 month and 15 days after the end of that month—the so-called 15–15–45 method. These changes were published in the Federal Register on November 20, 1978, and are to become effective July 1, 1980.

Committee bill.—In order to ease the transition to the new depositing schedule, the committee provision requires that FICA deposits from State and local governments will be due 30 days after the end of each month. The provision would be effective beginning July 1980. The committee recognizes that, in some instances, the thirtieth day following the end of a month would fall on a holiday or week end. In such circumstances, the committee intends that the provision be interpreted to require that any necessary payments be deposited no later than the preceding working day so that in all cases the overall 30 day limitation would not be exceeded.

ELIGIBILITY OF ALIENS FOR SSI

(Section 504 of the Bill)

Present law.—In order for an alien to be eligible for supplemental security income payments under present law and regulations, he must be lawfully admitted for permanent residence or otherwise permanently residing in the United States "under color of law." The latter category refers primarily to refugees who enter as conditional entrants or parolees. An alien seeking admission to the United States must establish that he is not likely to become a public charge. If a visa applicant does not have sufficient resources of his own, a U.S. consular officer may require assurance from a resident of the United States that

the alien will be supported. In addition, the Immigration and Nationality Act provides that an immigrant who becomes a "public charge" within 5 years of his entry into the United States may be deported if the cause of his becoming a "public charge" did not arise subsequent to his entry. However, receipt of SSI payments does not constitute becoming a "public charge" under present court interpretations of that term.

There have been complaints, particularly in a few States, that legal aliens have been applying for and receiving welfare benefits within a very short period after their entry into the country. As welfare recipients, these aliens are also generally eligible for the full range of medicaid benefits offered within their State.

Under the SSI statute, legal aliens are eligible for payments within 30 days after their arrival in the United States.

In a February 1978 report, "Number of Newly Arrived Aliens Who Receive Supplemental Security Income Needs To Be Reduced," the General Accounting Office estimated that about 214,000 aliens receive SSI, of which about 42,000 are newly arrived. The GAO observed in its report that "The public charge provisions of the Immigration and Nationality Act are ineffective in screening out aged (age 65 or older) aliens who may need SSI assistance soon after arrival in the United States. We estimate that 34 percent of the aged aliens who entered the United States during fiscal years 1973–75 were receiving SSI at the end of December 1976."

Committee bill.—The committee agrees with the recommendation of the GAO in its 1978 report that there should be a residency requirement to prevent assistance payments to newly arrived aliens. The committee bill would require an alien to reside in the United States for 3 years before he would be eligible for SSI. The provision would not apply to aliens under age 65 who are suffering from blindness or disability on the basis of conditions which arose after the time they were admitted to the United States.

DEMONSTRATION AUTHORITY TO PROVIDE SERVICES TO THE TERMINALLY ILL

(Section 505 of the Bill)

Present law.—Under present law there is a 5-month waiting period before benefits are payable under the disability insurance program. The committee has heard testimony that this waiting period sometimes constitutes an unreasonable hardship for persons who are suffering from a terminal illness, and that it should not apply in such cases. The committee has also heard testimony that it is difficult to justify waiving the waiting period for the terminally ill, while continuing to apply it for other disabled individuals, inasmuch as many other disabled workers are likely to have similar needs for income during the initial months of disability. In a memorandum by the Office of the Actuary of the Social Security Administration, which discusses the difficulty of estimating costs of this kind of proposal, it is observed that "Due to the difficulty involved in predicting whether an illness will result in premature death, especially within a limited time of 12 months or less, the level of accuracy of determinations of terminal illness cannot be expected to be very good. It is expected that many per-

sons will be found reasonably likely to die within 12 months of onset who will in fact survive the year. Similarly many persons will die within 12 months of onset who will not have been expected to do so." The actuary estimates that the long-range cost to the disability trust fund for the proposal would be .03 of taxable payroll.

Committee bill.—The committee believes that there is a need to find ways to improve assistance for persons who are terminally ill. The committee has been informed that the Department of Health, Education, and Welfare is currently undertaking a demonstration project through the Health Care Financing Administration to determine how best to provide the full range of services needed by persons who are terminally ill. The committee believes that it is appropriate for the Social Security Administration to participate in this project, and has included in its bill a provision authorizing up to $2 million a year to be used by SSA for the purpose of studying the impact on the terminally ill of provisions of the disability programs administered by the Social Security Administration. It is expected by the committee that this demonstration authority and the resulting reports which will be made on demonstration projects will provide the information necessary to enable the committee to amend the Social Security Act so as to provide the kinds of assistance most appropriate for individuals who are suffering from terminal illnesses.

WORK INCENTIVE AND OTHER DEMONSTRATION PROJECTS UNDER THE DISABILITY INSURANCE AND SUPPLEMENTAL SECURITY INCOME PROGRAMS

(Section 506 of the Bill)

Present law.—Under present law, the Secretary of Health, Education, and Welfare has no authority to waive requirements under titles II, XVI and XVIII of the Social Security Act to conduct experimental or demonstration projects.

Committee bill.—The committee believes that there is great need to improve the operations of the disability insurance, supplemental security income, and medicare programs as they relate to the disabled. These programs may, over time, affect the lives of nearly every individual and family in the Nation. It is highly important, therefore, that they be administered in the most efficient and effective way possible.

So far as the disability insurance program is concerned, one of the areas in which there is the most pressing need for information is the area of how to encourage disabled individuals to remain in and to return to the work force. Therefore, the committee has included in its bill as a matter of high priority specific authority for the waiver of certain benefit requirements of titles II, XVI, and XVIII to allow demonstration projects by the Social Security Administration to test ways in which to stimulate a return to work by disability beneficiaries. The bill requires SSA to report to the Congress on its findings on work incentives by January 1, 1983. The committee bill also authorizes waivers in the case of other disability insurance demonstration projects which SSA may wish to undertake, such as study of the effects of lengthening the trial work period, altering the 24-month waiting period for medicare benefits, altering the way the disability program is administered, earlier referral of beneficiaries for rehabilitation, and greater use of private contractors, employers and others to develop, perform or

otherwise stimulate new forms of rehabilitation. In addition, the committee bill includes authorization for waiver of requirements under title XVI to carry out experimental, pilot, or demonstration projects which are likely to assist in promoting the objectives or facilitate the administration of the SSI program. The bill provides for allocation of costs all such demonstration projects to the programs to which the project is most closely related. In the case of the SSI program, the Secretary is authorized to reimburse the States for the non-Federal share of payments or costs for which the State would not otherwise be liable. A final report on the projects authorized by this section would be due five years from enactment. (The committee recognizes that some elements of the experimental or demonstration projects might have to remain in effect beyond that date in order to assure the validity of the research.)

The committee bill includes a provision to waive certain requirements of the human experimentation statute, but to require that the Secretary in reviewing any application for any experimental, pilot or demonstration project pursuant to the Social Security Act would take into consideration the human experimentation law and regulations in making his decision on whether to approve the application. The committee does not intend that this provision modify the requirements of the human experimentation statute as they apply to direct medical experimentation with actual diagnosis or treatment of patients.

INCLUSION IN WAGES OF FICA TAXES PAID BY EMPLOYER

(Section 507 of the bill)

Present law.—In general, employers are required to pay an *employer* social security tax on the wages they pay their employees and to withhold from those wages an equal *employee* social security tax. As an alternative to this procedure, however, present law allows employers to assume responsibility for both the employer and employee taxes instead of withholding the employee's share from his wages. Under this alternative procedure, the payment by the employer of the employee's social security tax represents, in effect, an additional amount of compensation. However, existing law specifically exempts that amount of additional compensation from social security taxes. The net effect is that, for a given level of total compensation, somewhat lower social security taxes would be payable if the employer pays the employee social security tax instead of withholding it from the employee's wages.

Committee bill.—The committee recognizes that the provision of existing law has proved to be a matter of some convenience in certain employment relationships, particularly when relatively small amounts of wages are involved as in the case of domestic employment. However, the committee is seriously concerned over reports that there may be increasing use of the provision as a means of tax avoidance involving more substantial wage and tax payments than were envisioned when the existing law provisions were originally adopted. The committee has been advised that potential losses to the trust funds could run into the billions of dollars if the use of this provision continues to spread. For these reasons, the committee has decided to modify the provisions of existing law so that after 1980 any amounts of employee

social security taxes paid by an employer will be considered to constitute wages and will therefore be subject to social security taxation. This change will not apply in the case of payments made on behalf of domestic employees.

III. Cost Estimates and Actuarial Data Provided by the Administration

ACTUARIAL STATUS OF THE DISABILITY INSURANCE TRUST FUND UNDER THE BILL

Short term.—The status of the disability insurance trust fund was strengthened substantially by the Social Security Amendment of 1977, which increased the amount of tax contributions allocated to the trust fund. The Social Security Administration's current estimates, which are based on the Administration's Mid-Session Review assumptions, indicate that the disability insurance trust fund will amount to $5.4 billion at the end of 1979 and that it will grow rapidly during the following 5 years, reaching $28.5 billion by the end of 1984 under present law. The projected rapid growth of the DI trust fund is also due, in part, to a significant reduction in the number of benefits awarded to disabled workers after 1977. On the other hand, the old-age and survivors insurance trust fund is expected to continue to decline during the next 5 years, largely offsetting the rapid growth in the DI trust fund.

Estimates of the operations of the disability insurance trust fund under present law and under the program as modified by the committee bill are shown in tables 29 and 28 for calendar years 1978–84 and fiscal years 1978–84, respectively.

Long term.—On a long-term basis, the situation of the disability insurance trust fund under present law is favorable. The 1979 trustees' report reflects new assumptions of substantially reduced disability incidence rates in the future as compared with those assumed in earlier reports. These assumptions reflect the improved experience since 1975 and particularly in 1978. The reasons for this improvement are not wholly known.

The 1978 trustees' report indicated a long-term actuarial balance of −0.14 percent of taxable payroll in the disability insurance program, but the more favorable assumptions as to incidence rates in the 1979 report changed this to +0.21 percent. This bill, as amended by the Senate Finance Committee, provides a savings of 0.14 percent of taxable payroll, thereby raising the actuarial surplus to 0.35 percent. Although the DI program is therefore in an actuarially sound condition, its past history of volatility suggests caution in making any precipitous changes in financing.

The bill also has some impact on the old-age and survivors insurance program. The actuarial balance for that program would be reduced by .01 percent of taxable payroll to a level of −1.40.

The long-range estimates presented in this section are based on the intermediate assumptions described in the 1979 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds.

96TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
No. 96-944

SOCIAL SECURITY DISABILITY AMENDMENTS OF 1980

MAY 13, 1980.—Ordered to be printed

Mr. ULLMAN, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 3236]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 3236) to amend title II of the Social Security Act to provide better work incentives and improved accountability in the disability insurance program, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

That this Act may be cited as the "Social Security Disability Amendments of 1980".

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TITLE I—PROVISIONS RELATING TO DISABILITY BENEFITS UNDER OASDI PROGRAM

LIMITATION ON TOTAL FAMILY BENEFITS IN DISABILITY CASES

SEC. 101. (a) Section 203(a) of the Social Security Act is amended—

(1) by striking out "except as provided by paragraph (3)" in paragraph (1) (in the matter preceding subparagraph (A)) and inserting in lieu thereof "except as provided by paragraphs (3) and (6)";

TITLE I—PROVISIONS RELATING TO DISABILITY INSURANCE

Limit on Family Disability Insurance Benefits

(Sec. 101)

Present law.—The social security disability insurance program (DI) determines the amount of benefits payable based on an individual's previous earnings. The formula for determining disability benefits is the same as for retirement benefits. The benefit level is arrived at by applying a formula to the average indexed monthly earnings the individual had over the course of a period of years which approximates the number of years in which he could reasonably have been expected to be in the work force. For a retired worker, this period is equal to the number of years between the ages of 21 and 62. For a disabled worker, the number of years of earnings to be averaged ends with the year before he became disabled. In either case, the resulting averaging period is reduced by 5.

The basic benefit amount may be increased if the worker has a spouse or dependent children. Benefits for the spouse are payable if the spouse is over age 62 or if the spouse is caring for minor or disabled children. Benefits for children are payable if they are under age 18 or are disabled (as a result of a disability which existed in childhood) or if they are full-time students over age 18 but under age 22. The combined benefit for the worker and all dependents is limited by a family maximum provision to no more than 150 to 188 percent of the worker's benefit alone.

House bill.—The House bill limited total DI family benefits to the smaller of 80 percent of the worker's average indexed monthly earnings (AIME) or 150 percent of the worker's primary insurance amount (PIA). Under the provision, no family benefit would be reduced below 100 percent of the worker's primary benefit. The limitation was effective with respect to individuals becoming entitled to benefits on or after January 1, 1980.

Senate bill.—The Senate bill limited total DI family benefits to the smaller of 85 percent of the worker's AIME or 160 percent of the worker's PIA. As under the House bill, no family benefit would be reduced below 100 percent of the worker's primary benefit. The bill provided for the same effective date as the House bill except the limitation would be effective only with respect to individuals who *first* became entitled to benefits on or after January 1, 1980.

Conference agreement.—The conferees agreed to limit DI family benefits to the smaller of 85 percent of the worker's average indexed monthly earnings (AIME), as in the Senate bill, or 150 percent of the worker's primary insurance amount (PIA), as in the House bill. The limitation is effective only with respect to individuals who *first* become entitled to benefits on or after July 1, 1980.

Reduction in Dropout Years

(Sec. 102)

Present law.—Disabled workers are allowed to exclude up to 5 years of low earnings in averaging their earnings. However, at least 2 years of earnings must be used in the benefit computation.

House bill.—The House provision excluded years of low earnings in the computation of disability benefits according to the following schedule:

Worker's age:	*Number of dropout years*
Under 27	0
27 through 31	1
32 through 36	2
37 through 41	3
42 through 46	4
47 and over	5

The provision also allowed workers to drop out additional low earnings years if in those years the worker provided principal care of a child under age 6. In no case would the number of dropout years exceed 5.

Senate bill.—The Senate bill excluded years of low earnings in the computation of disability benefits according to the following schedule:

Worker's age:	*Number of dropout years*
Under 32	1
32 through 36	2
37 through 41	3
42 through 46	4
47 and over	5

There was no provision for allowing additional dropout years for child care.

Conference agreement.—The conferees agreed to exclude years of low earnings in the computation of disability benefits according to the following schedule (as in the House bill):

Worker's age:	*Number of dropout years*
Under 27	0
27 through 31	1
32 through 36	2
37 through 41	3
42 through 46	4
47 and over	5

The provision also would allow a disabled worker to drop out additional years from the computation period if in those years there was a child (of such individual or his or her spouse) under age 3 living in the same household substantially throughout each such year and the disabled worker did not engage in any employment in each such year. Dropout years for periods of childcare would be provided only to the extent that the combined number of childcare dropout years and dropout years provided under the regular schedule do not exceed 3.

The new schedule of dropout years applies to disabled workers who *first* become entitled to benefits after June 1980. The provision continues to apply to a worker until his death unless before age 62 he ceases to be entitled to disability benefits for 12 continuous months.

The provision allowing childcare dropout years would be effective for monthly benefits payable for months after June 30, 1981.

The provision in present law which requires that at least 2 years of earnings be used in the benefit computation is retained.

Elimination of Second Medicare Waiting Period

(Sec. 103)

Present law.—Beneficiaries of disability insurance (DI) must wait 24 consecutive months after becoming entitled to benefits to become eligible for medicare. If a beneficiary loses his eligibility and then becomes disabled again, another 24-consecutive-month waiting period is required before medicare coverage is resumed.

House bill.—The House provision eliminated the requirement that a person who becomes disabled a second time must undergo another 24-consecutive-month waiting period after becoming reentitled to benefits before medicare coverage is available to him. The amendment applied to workers becoming disabled again within 60 months, and to disabled widows or widowers and adults disabled since childhood becoming disabled again within 84 months.

Senate bill.—Same as House bill.

Conference agreement.—The conferees accepted the provisions of the House and Senate bills and agreed that the provision would be effective 6 months after enactment.

Extension of Medicare for an Additional 36 Months

(Sec. 104)

Present law.—Medicare coverage ends when disability insurance benefits cease.

House bill.—The House provision extended medicare coverage for an additional 36 months after cash benefits cease for a worker who is engaging in substantial gainful activity but has not medically recovered. (The first 12 months of the 36-month period was part of the new 24-month trial work period. See section 303.)

Senate bill.—Same as House bill.

Conference agreement.—The conferees accepted the provisions of the House and Senate bills and agreed to apply the new provision to disability beneficiaries whose disabilities have not been determined to have ceased prior to the 6th month after enactment.

Funding for Vocational Rehabilitation Services for Disabled Individuals

Present law.—Reimbursement from social security trust funds is now provided to State vocational rehabilitation agencies for the cost of vocational rehabilitation services furnished to disability insurance beneficiaries. The purpose of the payment is to accrue savings to the trust funds as a result of rehabilitating the maximum number of beneficiaries into productive activity. The total amount of the funds that may be made available for such reimbursement may not, in any year, exceed 1½ percent of the social security disability benefits paid in the previous year.

House bill.—Effective for fiscal 1982, the House bill eliminated trust fund financing for rehabilitation services but provided trust fund re-

imbursement for the Federal share (80%) to the General Fund of the U.S. Treasury and to the States for twice the State share (20%×2) of rehabilitation services which result in the performance by a rehabilitated individual of substantial gainful activity (SGA) for a continuous period of 12 months or which result in employment for 12 consecutive months in a sheltered workshop. It directed the Secretary of HHS to study alternative methods of providing and financing the costs of rehabilitation services to disabled beneficiaries in order to realize maximum savings to the trust funds and to submit a report with recommendations to the President and the Congress by January 1, 1980.

Senate bill.—The Senate bill made no change from present law.

Conference agreement.—The conferees agreed not to change the provisions of present law.

The conferees anticipate that the new method of allocating trust fund money to the States for rehabilitation of social security clients which was recently adopted administratively will continue and be intensified in the future. This method generally allocates the trust fund money based on the relative number of social security beneficiaries each State rehabilitates with earnings at the substantial gainful activity (SGA) level, provided that no State loses more than ⅓ of its previous year's funding. Currently, rehabilitation is considered to have been achieved when the client has been employed for two months. The managers expect that the measure of success, i.e., rehabilitation at the SGA level, will be modified as soon as administratively feasible so that the allocation formula will be based on the State's relative share of the total number of social security clients employed as a result of rehabilitation for no less than 6 months (although not necessarily consecutive) with earnings at the SGA level throughout the period. Furthermore, the managers expect that steps will be taken to develop procedures which will eventually result in the allocation being based on the State's relative share of total benefit terminations brought about by vocational rehabilitation services. The conferees instruct the Social Security Administration and the Rehabilitation Services Administration (recently transferred to the Department of Education) to continue to explore the possibility of developing more timely and effective methods of measuring performance in trust fund rehabilitations. The results of these efforts should be promptly communicated to the Ways and Means and Finance Committees.

TITLE II—PROVISIONS RELATING TO DISABILITY BENEFITS UNDER THE SSI PROGRAM

Benefits for Individuals Who Engage In Employment Activity

(Sec. 201)

Present law.—Under present law, an individual may qualify for SSI disability payments only if and for so long as he "is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." The Secretary of Health and Human Services is required to prescribe the criteria for determining when services performed or earnings derived from employment demonstrate an individual's ability to engage in substantial gainful activity (SGA). At the present time, the level of earnings established by the Secretary for determining whether an individual is engaging in SGA is $300 a month. An individual who in fact has earnings above this level (1) cannot become eligible for SSI disability and (2), if already eligible, will (after a 9-month trial work period) cease to be eligible.

Senate bill.—The Senate bill included an amendment which, on a demonstration basis, provided that a disabled recipient who loses his eligibility for regular SSI benefits because of performance of SGA would become eligible for a special benefit status, which would entitle him to cash benefits equivalent to those he would be entitled to receive under the regular SSI program. Persons who receive these special benefits would be eligible for medicaid and social services on the same basis as regular SSI recipients. States would have the option of supplementing the special Federal benefits. When the individual's earnings exceeded the amount which would cause the Federal SSI payment to be reduced to zero, the special benefit status would be terminated and the individual would not thereafter be eligible for any Federal SSI benefits or Federal cash benefits under the special benefits status unless he could reestablish his eligibility for SSI, which would include meeting the SGA limitation.

When a disabled SSI recipient's earnings rise to the point that he no longer qualifies for Federal SSI benefits, State supplementary payments or the special benefit status, he would nevertheless continue to retain eligibility for medicaid and social services as though he were an SSI recipient if the Secretary found (1) that termination of eligibility for these benefits would seriously inhibit the individual's ability to continue his employment, and (2) the individual's earnings were not sufficient to allow him to provide for himself a reasonable equivalent of the cash and other benefits that would be available to him in the absence of earnings. The provision allowing continuation of eligibility for med-

icaid and social services for persons whose earnings make them ineligible for cash benefits would also apply to SSI recipients who are blind.

The Senate provisions would be effective for 3 years, during which the Department would be required to provide for a separate accounting of funds expended under this provision.

Conference agreement.—The conference agreement follows the Senate bill effective January 1, 1981 with the addition of a pilot program under which States could provide medical and social services to certain persons with severe impairments whose earnings exceed the substantial gainful activity limits and who are not receiving SSI, special benefits, or medicaid.

Under this pilot program, for the purpose of assisting States in providing medical or social services to certain severely handicapped persons, $18 million in Federal funds would be available to States on an entitlement basis for a 3-year period beginning September 1, 1981. $6 million would be available to States through the end of fiscal 1982. An additional $6 million would be available for each of the two following fiscal years. Funds that are not used during each of the first two years could be carried forward by the State.

Funds would be allocated among the States in proportion to the number of disabled SSI recipients aged 18 to 65. Prior to the start of each fiscal year, each State that does not intend to use its allocation would so certify to the Secretary of Health and Human Services. If a State certifies that it will not use all or some portion of its funds for any fiscal year or years, its allocation (or the unused portion thereof) for the period covered by the certification will be reallocated by the Secretary of HHS among States participating in the program that can make use of additional funds.

From the allocated funds, the Secretary of HHS would pay each State 75 percent of the costs of operating an approved plan for providing medical and social services to severely handicapped individuals who have earnings in excess of the substantial gainful activity limits and are not receiving SSI, special benefits or medicaid, if the State determines:

(1) that the absence of these benefits would significantly inhibit the individual's ability to continue his employment; and

(2) that the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the cash and other benefits (SSI, medicaid and title XX) that would be available to him in the absence of those earnings.

(It is not intended that States would require an individual to obtain a determination as to the level of or potential eligibility for benefits which might be payable under the SSI, medicaid, and title XX programs in the absence of his earnings. Rather it is intended that each participating State would use generally available information concerning the benefits provided in that State under these programs to establish reasonable income limits to carry out this criterion.)

The State plan would have to include (1) a statement of intent to participate in the program; (2) a designation of the agency to administer the program; (3) a description of the eligibility criteria which the State will apply and the procedures for determining eligibility (which may not involve use of the Disability Determination Service which makes disability determinations for the DI and SSI programs

unless it is not feasible to use any other agency for the pilot program); and (4) a description of the services which the State intends to provide under the program. The State may submit a separate State plan or it may incorporate this plan as an amendment to its State administrative plan submitted to HHS under title XX. Under the pilot program, States could provide medical and social services through their medicaid and social services programs (not limited by eligibility criteria and scope of services under titles XIX and XX) but would receive Federal matching for those services under this provision rather than under title XIX or title XX. States could also provide services through some other mechanism if they found it appropriate.

States would be required to provide a report to HHS addressing the operation and results, emphasizing the work incentive effects, of the pilot program. On the basis of State reports, HHS would be required to report to the Congress. The report would be due not later than October 1, 1983; and should include, but not necessarily be limited to, relevant demographic information, earnings, employment information, and primary impairments of the individuals who received services under the pilot program, and the types of services they received. HHS would be required to publish final regulations to implement this program no later than nine months after the date of enactment.

Employment in Sheltered Workshops

(Sec. 202)

Present law.—Under present law, income from activity in a sheltered workshop that is part of an active rehabilitation program are not considered earned income for purposes of determining SSI payments, and therefore do not qualify for the earned income disregards ($65 a month plus ½ of additional earnings).

Senate bill.—The Senate bill provided that remunerations received in sheltered workshops and work activities centers would be considered earned income and therefore qualify for the earned income disregards.

Conference agreement.—The conference agreement follows the Senate bill and the provision would be effective October 1980.

Deeming of Parents' Income to Disabled or Blind Children

(Sec. 203)

Present law.—Present law requires that the parents' income and resources be deemed to a blind or disabled child who lives in the household with them and who is under age 18 in determining the child's eligibility for SSI, or under 21 in the case of an individual who is in school or a training program.

Senate bill.—Under the Senate bill, the deeming of parents' income and resources would be limited to disabled or blind children under age 18, whether or not the person is in school or training. Children receiving SSI who, on the effective date of the provision, are age 18 to 21 would be protected against loss of benefits due to this change.

Conference agreement.—The conference agreement follows the Senate bill and the provision would be effective October 1980.

TITLE III—PROVISIONS AFFECTING DISABILITY RECIPIENTS UNDER OASDI AND SSI PROGRAMS; ADMINISTRATIVE PROVISIONS

Termination of Benefits for Persons in Vocational Rehabilitation Programs

(Sec. 301)

Present law.—Under present law an individual is not entitled to DI and SSI benefits after he has medically recovered, regardless of whether he has completed the program of vocational rehabilitation in which he has been enrolled.

House bill.—The House bill provided that DI benefits will continue after medical recovery for persons in approved vocational rehabilitation plans or programs, if the Commissioner of Social Security determines that continuing in those plans or programs will increase the probability of beneficiaries going off the rolls permanently.

Senate bill.—The Senate bill included the same provision for SSI and DI beneficiaries except that the Secretary, rather than the Commissioner, would make the determination as to whether benefits should be continued.

Conference agreement.—The conference agreement accepts the Senate extension of the provision to SSI beneficiaries, but adopts the House provision that the Commissioner will make the determination that benefits should be continued.

The conference committee wishes to make clear that it expects that, in most cases, medical cessation of disability will result in the termination of benefits, as now occurs in all cases. The conferees are concerned that under present vocational rehabilitation procedures many individuals have been permitted to enter approved programs even when there is a reasonable expectation of medical recovery before the termination of the program. (This is demonstrated by the fact that an increasing number of individuals have been terminated from the benefit rolls while participating in a State approved vocational rehabilitation program who were at the time of enrollment in the program diaried for reexamination on the basis of the time-limited nature of their medical impairment.) It is not the intent of this provision to continue benefits in these cases. It is the intent of the provision to consider only those exceptional cases where the disabled beneficiary is not expected at the beginning of the program to recover medically before the end of the program, but he or she does recover and is no longer considered disabled within the meaning of the Social Security Act, although some residual functional limitation still remains.

The provision is effective 6 months after enactment.

Treatment of Extraordinary Work Expenses

(Sec. 302)

Present law.—Regulations issued under present law provide that, in determining whether an individual is performing substantial gainful activity (SGA), extraordinary expenses incurred by the individual in connection with his employment, and because of his impairment, are to be deducted to the extent that such expenses exceed what his expenses would be if he were not impaired. Regulations specify that expenses for medication or equipment which the individual requires to enable him to carry out his normal daily functions may not be considered work related, and may not be deducted even if they are also essential to the individual's employment.

House bill.—For purposes of DI, the House bill provided for a deduction from earnings of costs to the individual of extraordinary impairment-related work expenses, attendant care costs, and the cost of medical devices, equipment, and drugs and services (necessary to control an impairment) for purposes of determining whether an individual is engaging in substantial gainful activity, regardless of whether these items are also needed to enable him to carry out his normal daily functions.

Senate bill.—The Senate bill included the same provision, but also provided that the deduction would apply even where the individual does not pay the cost of the impairment-related work expenses (i.e. where the cost is paid by a third party). The bill added language giving the Secretary the authority to specify in regulations the type of care, services, and items that may be deducted, and provided that the amounts to be deducted shall be subject to such reasonable limits as the Secretary may prescribe. It also made the provision applicable to SSI.

Conference agreement.—The conferees adopted the Senate provision, but agreed that, for both programs, the disregard will be applied only where the individual paid the cost of the impairment related expense. In addition, impairment related work expenses would be disregarded in determining the monthly SSI payment of a disabled SSI recipient. It is the intent of the conferees that the regulations developed by the Secretary to carry out these provisions shall apply in a uniform manner to the determination of the amounts which may be deducted in both the DI and SSI programs. The provision is effective six months after enactment.

Extension of the Trial Work Period—Reentitlement to Benefits

(Sec. 303)

Present law.—Under the DI and SSI programs, when an individual completes a 9-month trial work period, and then in a subsequent month performs work constituting substantial gainful activity (SGA), his benefits are terminated. He obtains benefits for the first month in which he performs SGA (after the trial work period has ended) and for the 2 months immediately following. Under the DI program, widows and widowers are not entitled to a trial work period.

House bill.—The House bill, in effect, extended the trial work period under the DI program to 24 months. In the last 12 months of the 24-month period an individual who was performing substantial gainful activity immediately following the 9-month trial work period would not receive cash benefits while engaging in substantial work activity, but would automatically be reinstated to active benefit status if earnings fall below the SGA level.

The bill also provided that the same trial work period would be applicable to disabled widows and widowers (who are not permitted a trial work period at all under existing law).

Senate bill.—The Senate bill was the same as the House bill with technical language changes, and also made the provision generally applicable to the SSI program.

Conference agreement.—The conference accepted the provisions of the Senate bill, and agreed that the provision would be effective with respect to individuals whose disabilities have not been found to have terminated before the sixth month after enactment.

Administration by State Agencies

(Sec. 304 (a) (b) (e) (f) and (h))

Present law.—Present law provides for disability determinations to be performed by State agencies under an agreement negotiated by the State and the Secretary of HHS. Unlike the grant-in-aid programs, the relationship is contractual and State laws and practices are controlling with regard to many administrative aspects. State agencies make the determinations based on guidelines provided by the Department and the costs of making the determinations are paid from the disability trust fund in the case of DI claimants, or from general revenues in the case of SSI claimants, by way of advancements of funds or reimbursements to the contracting State agency. Present agreements allow both the State and the Secretary to terminate the agreement. The States generally may terminate with 12 months' notice and the Secretary may terminate if he finds the State has not complied substantially with any provision of the agreement.

House bill.—The House bill required that disability determinations be made by State agencies according to regulations or other written guidelines of the Secretary. It also required the Secretary to issue regulations specifying, in such detail as he deemed appropriate, performance standards and administrative requirements and procedures to be followed in performing the disability determination function "in order to assure effective and uniform administration of the disability insurance program throughout the United States." Certain operational areas were cited as "examples" of what the regulations may specify.

The bill also provided that if the Secretary found that a State agency is substantially failing to make disability determinations consistent with his regulations, the Secretary shall, not earlier than 180 days following his findings, terminate State administration and make the determinations himself. In cases of termination by the State, the State would be required to continue to make disability determinations for not less than 180 days after notifying the Secretary of its

intent to terminate. Thereafter, the Secretary would be required to make the determinations.

Senate bill.—The Senate bill was the same as the House bill, except that it:

(1) Deleted as an example of the kinds of matters which the Secretary's regulations may cover: "any other rules designed to facilitate or control or assure the equity and uniformity of the State's disability decision."

(2) Added language specifying that "Nothing in this section shall be construed to authorize the Secretary to take any action except pursuant to law or to regulations promulgated pursuant to law."

Conference agreement.—The conference agreement follows the Senate bill. The conference committee deleted the catch-all phrase of "any other rules designed to facilitate, or control, or assure the equity and uniformity of the State's disability determinations" as providing vague and unnecessary authority. The conference agreement provides that these changes will be effective beginning with the 12th month following the month in which the bill is enacted. Any State that has an agreement on the effective date of the amendment will be deemed to have given affirmative notice of wishing to make disability determinations under the regulations. Thereafter, it may give notice of termination which shall be effective no earlier than 180 days after the notice is given.

Protection of State Employees

(Sec. 304 (b) and (i))

Present law.—Under provisions of the Federal Personnel Manual, when the Federal Government takes over a function being carried out by a State, the Federal agency at its discretion may retain the State employees in their positions.

House bill.—The House bill required the Secretary to submit to the Committee on Ways and Means and the Committee on Finance by January 1, 1980, a detailed plan on how he expected to assume the functions of a State disability determination unit when this became necessary. The bill further provided that the plan should assume the uninterrupted operation of the disability determination function and the utilization of the best qualified personnel to carry out that function. If any amendment of Federal law or regulation was required to carry out such plan, a recommendation for such amendment was to be included in the plan for action, or for submittal by such committees, with appropriate recommendations to the committees having jurisdiction over the Federal civil service and retirement laws.

Senate bill.—The Senate bill was the same as the House bill except that it delayed the report by the Secretary to July 1, 1980, and required a report to Congress rather than to the Committees on Ways and Means and Finance. Also it added a requirement that if the Secretary assumes the disability determination function he must assure preference to State agency employees who are capable of performing duties in the disability determination process over any other individual in filling new Federal positions.

In addition, the Secretary would be prohibited from assuming the State functions until the Secretary of Labor determined that, with respect to any displaced State employees who were not hired by the Secretary, the State had made "fair and equitable arrangements to protect the interests of employees so displaced." The protective arrangements would have to include only those provisions provided under all applicable Federal, State, and local statutes, including the preservation of rights and benefits (including continuation of pension rights and benefits) under existing collective-bargaining agreements, the continuation of collective-bargaining rights, the assignment of affected employees to other jobs or to retraining programs, the protection of individuals against a worsening of their positions with respect to employment, the protection of health benefits and other fringe benefits, and the provision of severance pay.

Conference agreement.—The conference agreement follows the Senate bill except that the Secretary would not be required to provide a hiring preference to the administrator, deputy administrator, or assistant administrator (or comparable position) in the event that the Secretary found it necessary to assume the functions of a State agency. Although he would not be required to provide a preference to persons in those positions, he could do so if he determines that such action is appropriate. The effective date is the same as for the provision for administration of State agencies.

Federal Review of State Agency Decisions—Reversal of Decisions

(Sec. 304(c))

Present law.—Under current administrative procedures of the Social Security Administration, approximately 5 percent of initial disability claims adjudicated by the State disability determination units are reviewed by Federal examiners. This review occurs after the benefit has been awarded, i.e., it is a postadjudicative review. This is on a sample basis and varies from 2 percent in the larger States to 25 percent in the smaller States.

The Secretary has authority to reverse favorable decisions with respect to DI beneficiaries. He may reverse both favorable and unfavorable decisions in SSI.

House bill.—The House bill required Federal preadjudicative review of DI allowances according to the following schedule:

Decisions made in fiscal year:	Minimum percent reviewed
1980	15
1981	35
1982 and thereafter	65

Senate bill.—The Federal review of State agency decisions was to include both allowances and denials, according to the following schedule:

Decisions made in fiscal year:	Minimum percent reviewed
1981	15
1982	35
Thereafter	65

The Secretary would be given the authority to reverse decisions that are unfavorable to DI claimants.

Conference agreement.—The conference agreement follows the Senate schedule but provides (as in the House bill) for review only of allowances and continuances. The agreement follows the Senate bill as to granting authority to the Secretary to reverse denials.

The conference committee notes that the percentage requirements for preadjudicative review are nationwide requirements and that the Social Security Administration will determine whether they should be higher or lower on an individual State basis. The conferees also instruct the Secretary to report to the Ways and Means and Finance Committees by January 1982 concerning the potential effects on processing time and on the cost effectiveness of the requirement of the 65 percent review for fiscal year 1983, and thereafter. This provision is effective upon enactment.

Own-Motion Review of ALJ Decisions

(Sec. 304(g))

Present law.—After his claim has been denied by the State agency initially and on reconsideration, an applicant has the opportunity for a hearing before an administrative law judge (ALJ). In the past there had also been fairly extensive review of ALJ allowances and denials through own-motion review by the Appeals Council as authorized by the Administrative Procedure Act and the regulations of the Secretary. This own-motion review has almost been eliminated in recent years.

Senate bill.—The Secretary of Health and Human Services would be required to implement a program of reviewing, on his motion, decisions rendered by administrative law judges as a result of hearings under section 221(d) of the Social Security Act (the disability determination provisions). He would be required to report to Congress by January 1, 1982, on the progress of this program. In his report, he must indicate the percentage of such decisions being reviewed and describe the criteria for selecting decisions to be reviewed and the extent to which such criteria take into account the reversal rates for individual administrative law judges by the Secretary (through the Appeals Council or otherwise), and the reversal rate of State agency determinations by individual administrative law judges.

Conference agreement.—The conference agreement follows the Senate bill with a modification which strikes the language specifying what is to be included in the required report. The conferees believe the report should indicate the percentage of ALJ decisions being reviewed and describe the criteria for selecting decisions to be reviewed. The conferees are concerned that there is no formal ongoing review of social security hearing decisions. The variance in reversal rates among ALJ's and the high overall ALJ reversals of determinations made at the prehearing level indicate that there is a need for such review. The conferees recognize that, at the hearing level, the claimant appears for the first time before a decisionmaker and additional evidence is generally submitted. The conferees also recognize that there have been significant changes in State agency denial rates and that in certain

areas the ALJ's and State agencies have been operating with different policy guidelines. The report should identify the effects of these factors as well as any differences in standards applied by ALJ's.

Information to Accompany Secretary's Decision

(Sec. 305)

Present law.—There is no statutory provision setting a specific amount of information to explain the decision made on a claim for benefits.

House bill.—The House bill required that any decision by the Secretary with respect to all OASDI claimants shall provide notice to the claimant which includes:

A citation and discussion of the pertinent law and regulations,
A list and summary of the evidence of record, and
The Secretary's determination and the reason(s) upon which it is based.

Senate bill.—The Senate bill required that notices of disability denial to DI and SSI claimants shall contain a statement of the case, in understandable language, and include:

A discussion of the evidence, and
The Secretary's determination and the reason(s) upon which it is based.

Conference agreement.—The conference agreement follows the Senate bill.

The conference committee wishes to make clear that the Secretary's statement of the case be brief, informal, and not technical. The conferees do not contemplate that the statement would resemble the more formal "statement of the case" approach used by the Veterans Administration (VA) in its appeals proceedings. In addition, the conference committee wishes to make clear that where a written personalized explanation has been provided explaining why the individual will no longer be entitled to disability benefits (e.g. cessations of disability, adverse reopenings of determinations, etc.) it will not be necessary to provide this information again in the actual termination notice.

The provision is effective for decisions made on or after the first day of the 13th month following the month of enactment.

Limitation on Court Remand

(Sec. 307)

Present law.—Prior to filing an answer in a court case, the Secretary may, on his own motion, remand a case back to an ALJ. Similarly, the court itself, on its own motion or on motion of the claimant, has discretionary authority "for good cause" to remand the case back to the ALJ.

House bill.—The House bill limited the absolute authority of the Secretary of HHS to remand court cases. It required that such remands would be discretionary with the court upon a showing by the Secretary of good cause. A second provision relates to remands by the court. The bill provided that a remand would be authorized only on a showing that there is new evidence which is material, and that there

was good cause for failure to incorporate it into the record in a prior proceeding.

Senate bill.—Same as House.

Conference agreement.—The conference agreement includes this provision of the Senate and House bills effective upon enactment. The conferees have been informed that there are sometimes procedural difficulties which prevent the Secretary from providing the court with a transcript of administrative proceedings. Such a situation is an example of what could be considered "good cause" for remand. Where, for example, the tape recording of the claimant's oral hearing is lost or inaudible, or cannot otherwise be transcribed, or where the claimant's files cannot be located or are incomplete, good cause would exist to remand the claim to the Secretary for appropriate action to produce a record which the courts may review under 205(g) of the act. It is the hope of the conferees that remands on the basis of these breakdowns in the administrative process should be kept to a minimum so that persons appealing their decision are not unduly burdened by the resulting delay.

Time Limits for Decisions on Benefit Claims

(Sec. 308)

Present law.—There is no limit on the time that may be taken by the Social Security Administration to adjudicate cases at any stage of adjudication. Several Federal district courts have imposed such limits at the hearing level and numerous bills have been introduced to set such limits at various levels of adjudication.

House bill.—The House bill required the Secretary to submit a report to Congress recommending appropriate time limits for the various levels of adjudication of title II cases. In recommending the limits, the Secretary was to give adequate consideration to both speed and quality of adjudication.

Senate bill.—Same as House bill.

Conference agreement.—The conferees accepted the provision of the House and Senate bills but with the Senate due date of July 1, 1980.

Payment for Existing Medical Evidence

(Sec. 309)

Present law.—Authority does not now exist to pay physicians and other potential sources of medical evidence for medical information already in existence when a claimant files an application for disability insurance benefits. Such authority does exist in the SSI program.

House bill.—The House bill would provide that any non-Federal hospital, clinic, laboratory, or other provider of medical services, or physician not in the employment of the Federal Government, which supplies medical evidence required by the Secretary for making determinations of disability, shall be entitled to payment from the Secretary for the reasonable cost of providing such evidence.

Senate bill.—The Senate bill included the same provision except that payment for evidence would be made to the provider only when such evidence is "requested" and required by the Secretary.

Conference agreement.—The conference agreement follows the Senate bill and is effective six months after enactment.

Payment for Certain Travel Expenses

(Sec. 310)

Present law.—Explicit authority does not exist under the Social Security Act to make payments from the trust funds to individuals to cover travel expenses incident to medical examinations requested by the Secretary in connection with disability determinations, and to applicants, their representatives, and any reasonably necessary witnesses for travel expenses incurred to attend reconsideration interviews and proceedings before administrative law judges. Such authority now is being provided annually under appropriation acts.

House bill.—The House bill provided permanent authority for payment of travel expenses incident to medical examination and the travel expenses of individuals (and their representatives in the case of reconsideration and ALJ hearings) resulting from participation in various phases of the DI adjudication process.

Senate bill.—The Senate bill included the same provision and extended it to include SSI and medicare and all determinations under title II. However, a limitation on air travel costs included in the House bill was omitted in the title II authority.

Conference agreement.—The conference agreement follows the Senate bill with a modification to include the limitation on air travel costs.

The conference committee wishes to make it clear that this provision does not authorize reimbursement of a claimant's travel expenses in going to and from Social Security offices to file requests for reconsideration or to discuss the reconsideration decision. It is the intent of this provision to provide reimbursement only in the cases of those claimants who are entitled, as part of the reconsideration process, to engage in a face-to-face interview with a State agency decisionmaker if this procedure is implemented by the Social Security Administration.

Periodic Review of Disability Determinations

(Sec. 311)

Present law.—Administrative procedures now provide that a disability beneficiary's continued eligibility for benefits be reexamined only under a limited number of circumstances (i.e., where there is a reasonable expectation that the beneficiary will show medical improvement).

House bill.—The House bill provided that there will be a review of the status of disabled beneficiaries whose disability has not been determined to be permanent at least once every three years. This review would be in addition to, and not considered as a substitute for, any other reviews which are required.

Senate bill.—The Senate bill included the same provision except that even cases where the initial prognosis shows the probability that the condition will be permanent would be subject to review made at such times as the Secretary determines to be appropriate.

Conference agreement.—The conference agreement follows the Senate bill and is effective January 1982.

Report by Secretary

(Sec. 312)

Senate bill.—The Senate bill required the Secretary to make a full and complete report to the Congress on the effects of the provisions included in the first three titles of the bill.

Conference agreement.—The conferees agreed to the Senate amendment, with the understanding that the report will address such questions as the work incentive effects of relevant provisions, administrative problems involved in the implementation and operation of the provisions, and cost and caseload impact with respect to both the DI and SSI programs. The report is due by January 1985.

Scope of Federal Court Review—Findings of Fact

Present law.—The U.S. District Court shall have power to enter upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the case for a hearing. The findings of the Secretary as to any fact if supported by substantial evidence, shall be conclusive.

Senate bill.—The Senate bill modified the scope of Federal court review so that the Secretary's determinations with respect to facts in Title II and Title XVI would be conclusive, unless found to be arbitrary and capricious. The substantial evidence requirement would be deleted.

Conference agreement.—The conference agreement deletes the provisions of the Senate bill because of the uncertainty as to the ramifications of the rule proposed and the concern that the administrative process is not operating with the degree of credibility which would justify elimination of the "substantial evidence rule". The provision mandating pre-effectuation review of State agency allowances and Appeals Council own motion review of ALJ decisions eventually should enhance the validity of the process and lead to the need for less reliance on judicial review. The conference committee believes that the National Commission on Social Security should examine the disability adjudication and appeals process generally and deal specifically with such elements as the Administration proposals for judicial review in addition to alternative approaches such as a Disability Court. The problem of the great number of disability court cases, unevenness of courts in applying the substantial evidence rule and varying interpretations of crucial elements of the program in different judicial circuits, is worthy of further study.

The conference committee would like to reiterate what both committees stated in their reports on Public Law 94–202 that the courts should interpret the substantial evidence rule with strict adherence to its principles since the practice of some courts in making *de novo* factual determinations could result in very serious problems for the Federal judiciary and the social security programs.

TITLE IV—PROVISIONS RELATING TO AFDC AND CHILD SUPPORT PROGRAMS

AFDC Work Requirement

(Sec. 401)

Present law.—Recipients of Aid to Families with Dependent Children who are not specifically exempt are required to register for manpower services, training, and employment as a condition of AFDC eligibility. Those who are exempt from the registration requirement are children under age 16, persons caring for a child under age 6, persons who are ill or needed as the caretaker for someone in the home who is ill, or persons who are remote from a work incentive program (WIN) project.

Assistance may be terminated "for so long as" an individual (who has been certified by the welfare agency as ready for employment or training) refuses without good cause to participate in employment or training under WIN. Under court interpretation WIN sanctions may be applied only "for so long as" there is refusal, thus allowing a recipient to move on and off AFDC without being subject to any specific period during which his benefits may be terminated.

Federal matching for WIN programs is 90 percent. The State matching share of 10 percent may be either in cash or in kind with respect to manpower activities. State matching for supportive services must be in cash.

Senate bill.—The Senate bill added "other employment related activities" to the types of activities for which AFDC recipients are required to register. These are described in the committee report as including employment search. The bill also specifically required that necessary social and supportive services be provided during any employment search activities under the WIN program. These services would be authorized to be provided to registrants prior to certification.

The bill authorized the Secretaries of Labor and HEW (now HHS) to establish, by regulation, the period of time during which an individual would not be eligible for assistance in the case of refusal without good cause to participate in a WIN program. In addition, the present law provision for a 60-day counseling period for persons who refuse to participate was eliminated.

The bill also: required that State supportive service units be colocated with manpower units to the maximum extent feasible; allowed State matching for supportive services to be in cash or in kind; clarified that income from WIN public service employment is not fully excluded in determining benefits (there would be no disregard of the first $30 a month plus one-third of additional earnings); added to the individuals who are exempt from registration for WIN, individuals who are working at least 30 hours a week.

Conference agreement.—The conferees agreed to the Senate provision, with amendments. The conference agreement provides that the criteria for appropriate work and training to which an individual may be assigned under section 432(b) (1), (2), and (3) shall apply in the case of work to which an individual may be referred as part of employment search programs conducted under the work incentive program. In other words, job referral under the new employment search provision would be limited to jobs that meet the current WIN regulations relating to appropriate employment. (Present regulations provide limits as to reasonable travel time, provision for necessary supportive services, requirements for wages, health and safety, and others.)

In addition, the conferees agreed to limit an individual's job search period to 8 weeks in one year, and added a requirement that there be timely reimbursement of any employment search expenses paid for by the individual.

Under the conference agreement, the provisions relating to termination of assistance and treatment of PSE earnings are effective upon enactment. Other provisions are effective September 30, 1980.

Use of IRS to Collect Child Support for Non-AFDC Families

(Sec. 402)

Present law.—Present law authorizes States to use the Federal income tax mechanism for collecting support payments for families receiving AFDC, if the States have made diligent and reasonable efforts to collect the payments without success and the amount sought is based on noncompliance with a court order for support. States have access to IRS collection procedures only after certification of the amount of the child support obligation by the Secretary of Health and Human Services. The State must agree to reimburse the U.S. for any costs involved in making the collection.

Senate bill.—The Senate bill authorized use of IRS collection mechanisms in the case of families not receiving AFDC, subject to the same certification and other requirements that are now applicable in the case of families receiving AFDC.

Conference agreement.—The conferees agreed to the Senate provision, with an effective date of July 1, 1980.

Safeguards Restricting Disclosure of Certain Information Under AFDC and Social Services

(Sec. 403)

Present law.—Current law restricts the use or disclosure of information to purposes directly connected with: AFDC, SSI, Medicaid, or the Title XX social services program; any investigation, prosecution, or criminal or civil proceeding related to the administration of these programs; or the administration of any other federally assisted program providing assistance or services based on need. Present law also prohibits the disclosure to any committee or legislative body of

information which identifies by name or address any applicant for, or recipient of, such assistance or services.

Senate bill.—The Senate bill modified titles IV and XX to allow the disclosure of information regarding individuals assisted under the State's plan (1) for purposes of any authorized audit conducted in connection with the administration of the program including an audit performed by a legislative audit body, and (2) to the Committee on Finance and Committee on Ways and Means.

Conference agreement.—The conference agreement includes the provisions of the Senate bill, except that disclosure of information containing names and addresses of individual recipients to the Committees on Finance and Ways and Means would not be authorized. The conferees note that this limitation pertains only to names and addresses. As under existing law, the two committees would otherwise have full access to data and findings concerning the operations of these programs and would be able to request and receive the results of program audits. The conferees note that there is a similar provision relating to disclosure of information in H.R. 3434, which is now pending before the Congress. The conferees understand that the provisions in both bills will have the same result of allowing disclosure for purposes of any authorized audit by a legislative audit entity. The provision is effective on September 1, 1980.

Federal Matching for Child Support Activities Performed by Court Personnel

(Sec. 404)

Present law.—Present law requires that State child support plans provide for entering into cooperative arrangements with appropriate courts and law enforcement officials to assist the child support agency in administering the program. Federal regulations allow States to claim Federal matching for the compensation of district attorneys, attorneys general, and similar public attorneys and prosecutors and their staff. However, States may not receive Federal matching for expenditures (including compensation) for, or in connection with, judges or other court officials making judicial decisions, and other supportive and administrative personnel.

Senate bill.—The Senate bill authorized Federal matching funds for expenditures of courts (including, but not limited to compensation for judges or other persons making judicial determinations and other support and administrative personnel of courts who perform Title IV–D functions), but only for those functions specifically identifiable as IV–D functions. Matching would be provided only for expenditures in excess of levels of spending in the State for these activities in calendar 1978.

Conference agreement.—The conferees agreed to the Senate provision, with an amendment deleting the authorization for compensation of judges or other officials making judicial decisions, but allowing the authorization for expenditures for their administrative or support personnel, such as the bailiff, stenographer, and court reporter. The provision is effective for expenditures after July 1, 1980.

Child Support Management Information System

(Sec. 405)

Present law.—Federal matching for child support administrative costs, including the cost of establishing and using management information systems, is provided at a rate of 75 percent.

Senate bill.—The Senate bill increased Federal matching to 90 percent for the costs of developing and implementing child support management information systems, retaining the present 75 percent matching rate for the costs of operating such systems. The bill required the Secretary to provide technical assistance to the States and provided that a State system must meet certain specified requirements in order to receive Federal matching. The Senate bill further required continuing review by the Secretary of HHS of State systems.

Under the bill States choosing to establish and operate systems must include as part of such systems (1) the ability to control and monitor all the factors of the support collection and paternity determination process, (2) interface with the AFDC program, (3) security against access to data, and (4) the ability to provide management information on all cases from application through collection and referral.

Conference agreement.—The conferees agreed to the Senate amendment, with an effective date of July 1, 1981.

AFDC Management Information System

(Sec. 406)

Present law.—States receive 50 percent Federal matching for costs of administering their AFDC programs; there is no special funding for computer systems.

Senate bill.—The Senate bill provided 90 percent Federal matching to States for the cost of developing and implementing computerized AFDC management information systems and 75 percent for the cost of their operation. The Secretary of Health and Human Services would be required to approve State systems as a condition of Federal matching (both initially and on a continuing basis). In order to qualify for this increased match, a State system would have to include certain specified characteristics, including (1) ability to provide data on AFDC eligibility factors, (2) capacity for verification of factors with other agencies, (3) capability for notifying child support, food stamp, social services, and medicaid programs of changes in AFDC eligibility and benefit amount, (4) compatibility with systems in other jurisdictions, and (5) security against unauthorized access to or use of data in the system. The Department would be required to provide technical assistance to the States on a continuing basis.

Conference agreement.—The conferees agreed to the Senate provision to increase to 90 percent the matching for the cost of developing and implementing computerized systems. The 90 percent matching includes the purchase or rental of computer equipment and software. However, the matching rate for operating such systems would remain at 50 percent. The provision is effective July 1, 1981.

Child Support Reporting and Matching Procedures

(Sec. 407)

Present law.—Present law requires that the Office of Child Support Enforcement (1) maintain adequate records (for both AFDC and non-AFDC families) of all amounts collected and disbursed, and of the costs of collection and disbursement, and (2) publish periodic reports on the operation of the program in the various States and localities and at national and regional levels and the major problems encountered in implementing the program. The law also provides that the States will maintain for both AFDC and non-AFDC families a full record of collections, disbursements, and expenditures and of all other activities related to its child support programs. An adequate State reporting system is required.

Senate bill.—The Senate bill would prohibit advance payment of the Federal share of State administrative expenses for a calendar quarter unless the State has submitted a complete report of the amount of child support collected and disbursed for the calendar quarter which ended 6 months earlier. It would also require the Department of Health and Human Services to reduce the amount of the payments to the State by the Federal share of child support collections made but not reported by the State.

Conference agreement.—The conferees agreed to the Senate bill, with an effective date of January 1, 1981.

Access to Wage Information for Child Support Program

(Sec. 408)

Present law.—Present law requires the Secretary of HHS to make available to States and political subdivisions wage information contained in the records of the Social Security Administration which is necessary to determine eligibility for AFDC. The law requires the Secretary to establish safeguards to insure that information is used only for authorized purposes. There is no similar provision for purposes of child support.

In addition, present law requires agencies that administer State unemployment compensation to make available to States and political subdivisions wage information contained in their records which is necessary to determine eligibility for AFDC, and requires the Secretary to establish safeguards to insure that information is used only for authorized purposes. There is no similar provision for purposes of child support.

Under the Internal Revenue Code, tax return information may be disclosed by IRS (1) to the Social Security Administration for purposes of administering the Social Security Act, and (2) to Federal, State and local child support agencies for establishing and enforcing child support obligations under the child support program. Agencies receiving this information must comply with specified safeguards. SSA may not transfer information it receives from IRS to State and

local agencies. Information must be obtained by the agencies directly from IRS.

Senate bill.—The Senate bill provided the same requirement for disclosure of wage information (other than tax return information) for purposes of the child support program as exists in present law for purposes of AFDC. It also provided the same requirement for provision of wage information by State unemployment compensation agencies for purposes of the child support program as exists in present law for purposes of AFDC.

The Senate bill required SSA to disclose tax return information obtained from IRS with respect to earnings from self-employment and wages (1) to officers and employees of HHS, and (2) to officers and employees of an appropriate State or local agency, body, or commission. Information could be disclosed for purposes of establishing, determining, and enforcing child support obligations under the child support program.

Agencies or commissions authorized to receive tax return information could disclose such information to any person to the extent necessary in connection with the processing and use of information necessary for the purpose of establishing, determining, or enforcing child support obligations.

Conference agreement.—Under the conference agreement, certain tax return information must be disclosed by the Social Security Administration to State and local child support enforcement agencies, as follows.

The conferees agreed to amend the Internal Revenue Code to provide that, upon written request, the Commissioner of Social Security shall directly disclose return information with respect to net earnings from self-employment, wages, and payments of retirement income to officers and employees of a State or local child support enforcement agency. Disclosure will be allowable only for purposes of, and to the extent necessary in, establishing and collecting child support obligations from, and locating individuals owing child support obligations.

Any agency receiving information must comply with conditions specified in current law for safeguarding information. Under these safeguards, information may be used on a computer in uncoded form if the computer is used only by the child support enforcement agency. If this information is used on computer systems shared with agencies which are not child support agencies, it must be introduced into the system and coded so that it is available only to officers and employees of the child support enforcement agency. Generally, disclosure to individuals other than officers and employees of the child support enforcement agency would not be authorized; however, the information may be disclosed to the taxpayer to whom the information pertains. This provision is effective on enactment.

In addition, the conferees agree to amend title III of the Social Security Act, Grants to States for Unemployment Compensation Administration, to require the State agency administering the unemployment compensation program to disclose directly, upon request and on a reimbursable basis, to officers or employees of any State or local child support enforcement agency any wage information contained in

the records of the State agency. The agency is also required to establish safeguards necessary (as determined by the Secretary of Labor in regulations) to insure that information is used only for purposes of establishing, and collecting child support obligations from, and locating, individuals owing such obligations. If the Secretary of Labor finds that the State agency has failed to comply with requirements of this provision, he must notify the agency that further payments of administrative costs will not be made to the State until he is satisfied that there is no longer any such failure. The provision is effective July 1, 1980.

TITLE V—OTHER PROVISIONS RELATING TO THE SOCIAL SECURITY ACT

Relationship Between Social Security and SSI Benefits

(Sec. 501)

Present law.—Under existing law, an individual eligible under both the OASDI and SSI programs, whose determination of eligibility for OASDI is delayed, can in some cases receive full payment under both programs for the same months. Because SSI benefits are determined on a quarterly basis, retroactive OASDI benefits are counted as income for purposes of reducing SSI benefits only for the quarter in which retroactive benefits are received.

Senate bill.—The Senate bill would require the Secretary to offset, against retroactive benefits under OASDI, amounts of SSI benefits paid for the same period. The amount of the offset would equal the amount of SSI that would not have been paid had OASDI benefits been paid on time. From the amount of social security benefits offset under the provision, States would be reimbursed for any amounts of State supplementary payments that would not have been paid; the remainder would be credited to general revenues.

Conference agreement.—The conference agreement follows the Senate bill effective with the 13th month after the month of enactment. The conferees do not intend that this adjustment of benefit amounts will have the effect of removing any individual on a retroactive basis from his status as an eligible individual under the SSI program.

Extension of the Term of the National Commission on Social Security

(Sec. 502)

Present law.—The terms of the members of the National Commission on Social Security are to last 2 years, and the Commission itself will expire on January 11, 1981.

Senate bill.—The Senate bill extended for 3 months the expiration date of the National Commission on Social Security and the terms of its members. Under the Senate provision, the Commission's work and the terms of its members would end on April 1, 1981, and its final report will be due on January 11, 1981.

Conference agreement.—The conference agreement follows the Senate bill. The conferees request that the National Commission also examine and report on the serious administrative problems currently facing the Social Security Administration which include growing program responsibility without adequate staffing and the effect of the three reorganizations within the last five years.

Depositing of Social Security Contributions with Respect to State and Local Covered Employment

(Sec. 503)

Present law.—Since 1951 coverage of State and local government employment has been provided through voluntary agreements between the Federal government and the individual States. The Social Security Act provides that the regulations of the Secretary shall be designed to make the deposit requirements imposed on the States the same, as far as practicable, as those imposed on private employers. Present regulations, in effect since 1959, require each State to deposit contributions with the Federal Reserve Bank and file wage reports of covered employees within 1 month and 15 days after the close of each calendar quarter.

Public Law 94–202 was enacted in 1976 to assure adequate consideration of any change in the deposit requirements. Public Law 94–202 requires that at least 18 months must elapse between the publication of regulations changing the deposit schedule and the effective date of the change.

On November 20, 1978, the Department published final regulations to become effective July 1, 1980, which will require more frequent deposits by the States. The new regulations will require the States to make deposits within 15 days after the end of each of the first 2 months of the calendar quarter and within 1 month and 15 days after the end of the final month of the quarter.

Senate bill.—The Senate bill required that, in lieu of the schedule of deposits called for in the regulation, effective July 1, 1980 the States would make deposits within 30 days after the end of each month. The provisions of P.L. 94–202 would not be applicable to changes in regulations that are designed to carry out this statutory change.

Conference agreement.—The conference agreement follows the Senate bill.

Aliens Receiving SSI

(Sec. 504)

Present law.—In order for an alien to be eligible for supplemental security income payments under present law and regulations, he must be lawfully admitted for permanent residence or otherwise permanently residing in the United States "under color of law." An alien seeking admission to the United States must establish that he is not likely to become a public charge. If a visa applicant does not have sufficient resources of his own, a U.S. consular officer may require assurance from a resident of the United States that the alien will be supported by a "sponsor" in the United States. Legal aliens are eligible for SSI payments 30 days after their arrival in the United States.

Senate bill.—The Senate bill required an alien to reside in the United States for 3 years before he would be eligible for SSI. The provision would not apply to refugees, or to aliens who are suffering from blindness or disability on the basis of conditions which arose after the time they were admitted to the United States. The provision would also not apply in cases in which the support agreement is unenforceable under the Immigration and Nationality Act, or in cases in which the

sponsor fails to provide support and the alien demonstrates to the satisfaction of the Attorney General that he did not participate in fraud or misrepresentation on the part of the sponsor, that he believed that the sponsor had adequate resources to support him, and that he could not have reasonably foreseen the refusal or inability of the sponsor to comply with the support agreement.

The Senate bill would amend the Immigration and Nationality Act to make the sponsor's affidavit of support a legally enforceable contract. The sponsor must agree that for 3 years after admission of the alien he will provide such financial support (or equivalent in-kind support) as is necessary to maintain the alien's income at an amount equal to the amount the alien would receive if he were eligible for SSI (including any State supplementary payment). The agreement could be enforced with respect to an alien against his sponsor in a civil action brought by the Attorney General or by the alien in a U.S. District Court. It could also be enforced by any State or political subdivision which is making payments to the alien under any program based on need. In the latter case, the action could be brought in a U.S. District Court if the amount in controversy were $10,000 or more, or in the State courts without regard to the amount in controversy. The agreement could be excused and unenforceable under certain specified circumstances, including death or bankruptcy of the sponsor. Also, the Senate bill provided that a sponsor who intentionally reduces his income or assets in order to be excused from his agreement would be responsible for the repayment of any public assistance provided the alien during the time the agreement was excused.

Conference agreement.—The conferees agreed that for purposes of eligibility for Supplemental Security Income (SSI) benefits, legally admitted aliens who apply for SSI benefits after September 30, 1980 will be deemed to have the income and resources of their immigration sponsors available for their support for a period of 3 years after their entry into the United States, unless the alien becomes blind or disabled after entry. Under the agreement the eligibility of such aliens for SSI will be contingent upon their obtaining the cooperation of their sponsors in providing the necessary information to Social Security to carry out this provision. The provision would not apply to any alien who is (1) admitted to the United States as a result of the application, prior to April 1, 1980, of the provisions of section 203(a)(7) of the Immigration and Nationality Act; (2) admitted to the United States as a result of the application, after March 31, 1980, of the provisions of section 207(c)(1) of such Act; (3) paroled into the United States as a refugee under section 212(d)(5) of such Act; or (4) granted political asylum by the Attorney General.

During the 3 years after entry into the United States, an alien may be eligible for SSI benefits only if his sponsor agrees to and does provide such information as the Secretary of Health and Human Services may require to carry out this provision. The alien and sponsor shall be jointly and severably liable to repay any SSI benefits which are incorrectly paid because of the sponsor's providing of misinformation or because of his failure to report, and any such incorrect payments which are not repaid would be withheld from any subsequent payments for which the alien or sponsor are otherwise eligible under the Social Security Act.

In deeming a sponsor's income to an alien under this provision, the alien's SSI benefit would be reduced by the amount of any income deemed to him. Income deemed to the alien would be considered unearned income and would thus result in a dollar-for-dollar reduction in benefits (subject to the $20 a month unearned income exclusion). The amount to be deemed would be equal to the gross income of the sponsor and his spouse reduced by an amount equal to a full SSI benefit for the sponsor and an amount equal to one-half of a full SSI benefit for each other person for whom the sponsor is legally responsible. (Income of a child, e.g., AFDC or SSI payments, which is specifically provided to or on behalf of a child in the household of the sponsor would not be included.) Except for the deeming provision, the alien's SSI benefit would be computed in the same manner as under existing law except that in-kind support and maintenance received by an alien living in the household of the sponsor (or sponsor's spouse) shall not result in the application of the one-third reduction. Income in the form of support or maintenance in cash or kind by the sponsor (or sponsor's spouse) would not be counted as income or resources to the extent such income or resources is taken into account in determining the amount of income and resources to be deemed from the sponsor to the alien.

On the same basis, the assets of the sponsor and his spouse would be determined as under SSI. Any resources in excess of this amount allowable under SSI ($1,500 if the sponsor is single, $2,250 for a couple) would be considered to be resources of the alien in addition to whatever resources the alien has in his own right.

Under the conference agreement, an alien applying for SSI would be required to make available to the Social Security Administration any documentation concerning his income or resources or those of his sponsor (if he has one) which he provided in support of his immigration application. The Secretary of Health, and Human Services would also be authorized to obtain copies of any such documentation from other agencies (i.e., State Department or Immigration and Naturalization Service). The Secretary of HHS would also be required to enter into cooperative arrangements with the State Department and the Justice Department to assure that persons sponsoring the immigration of aliens are informed at the time of sponsorship that, if the alien applies for public assistance, the sponsorship affidavit will be made available to the public assistance agency and the sponsor may be required to provide further information concerning his income and assets in connection with the alien's application for assistance.

Work Incentive and Other Demonstration Projects under the Disability Insurance and Supplemental Security Income Programs

(Sec. 505)

Present law.—The Secretary of Health and Human Services has no authority to waive requirements under titles II, XVI, and XVIII of the Social Security Act to conduct experimental or demonstration projects.

House bill.—The House bill authorized waiver of benefit requirements of the DI and medicare programs to allow demonstration proj-

ects by the Social Security Administration to test ways in which to stimulate a return to work by disability beneficiaries, and required periodic reports and a final report on the findings by January 1, 1983.

Senate bill.—The Senate bill contained a similar provision but required an interim report by January 1, 1983 and final one by 5 years after the date of enactment. The provision further authorized experiments and demonstration projects which were likely to promote the objectives or improve the administration of the SSI program. The provision provided for allocation of costs of all such demonstration projects to the programs to which the project was most closely related. In the case of the SSI program, the Secretary was authorized to reimburse the States for the non-Federal share of payments or costs for which the State would not otherwise be liable.

The Senate provision also authorized waivers in the case of other disability insurance demonstration projects which SSA wished to undertake, such as study of the effects of lengthening the trial work period, altering the 24-month waiting period for medicare benefits, altering the way the disability program is administered, earlier referral of beneficiaries for rehabilitation, and greater use of private contractors, employers and others to develop, perform or otherwise stimulate new forms of rehabilitation.

The Senate bill further authorized waiver of certain nonmedical requirements of the human experimentation statue, P.L. 93–348 (such as conditions of payment of benefits or copayments, deductibles or other limitations), but requires that the Secretary in reviewing any application for any experimental, pilot or demonstration project pursuant to the Social Security Act would take into consideration the human experimentation law and regulations in making his decision on whether to approve the application.

Conference agreement.—The conferees agreed to the provisions of the House and Senate bills with the exception of the Senate provision authorizing waiver of certain nonmedical requirements of the human experimentation statute. This latter provision was deleted.

With respect to SSI experiments, the Secretary would not be authorized to carry out any project that would result in a substantial reduction in any individual's total income and resources as a result of his participation in the project. The Secretary could not require an individual to participate in a project and would have to assure that the voluntary participation of individuals in any project is obtained through an informed written consent agreement which satisfies requirements established by the Secretary. The Secretary would also have to assure that any individual could revoke at any time his voluntary agreement to participate. The Secretary, to the extent feasible, would be required to include recipients under age 18. The Secretary would also be required to include projects necessary to ascertain the feasibility of treating alcoholics and drug addicts to prevent the onset of irreversible medical conditions which may result in permanent disability.

The new provisions would be applicable to both applicants and beneficiaries, and would be effective upon enactment.

Provisions Relating to the Terminally Ill

(Sec. 506)

Present law.—Under the OASDI program the waiting period is the earliest period of 5 consecutive months in which an individual is under a disability. An individual is determined disabled if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or is expected to last for not less than 12 months. If an individual becomes disabled and applies for benefits in the same month, the waiting period will be satisfied 5 months after the month of application. With all other conditions of eligibility having been met, benefits will be due for the sixth month after the month in which the disabling condition begins, and will be paid on the third day of the seventh month.

The waiting period cannot begin until the individual is insured for benefits (i.e., the individual has satisfied the quarters of coverage requirements). If the disabling condition begins before an individual is insured for benefits, the waiting period can begin only with the first month in which the individual has insured status.

If a worker is applying for benefits after having been entitled to DI benefits previously (or had a previous period of disability) within 5 years prior to the current application, the waiting period requirement does not have to be met again.

Senate bill.—The Senate bill eliminated the waiting period for persons with a terminal illness, i.e., a medically determinable physical impairment which is expected to result in the death of such individual within the next 12 months and which has been confirmed by two physicians in accordance with the appropriate regulations.

The provision was to be effective for applications filed in or after the month of enactment, or for disability decisions not yet rendered by the Social Security Administration or the courts prior to the month of enactment.

Benefits would be payable beginning October 1980.

Conference agreement.—The conferees did not agree to the Senate provision eliminating the waiting period for persons with a terminal illness, but in lieu thereof agreed to a provision authorizing up to $2 million a year to be used by SSA for the purpose of participating in a demonstration project relating to the terminally ill which is currently being conducted by the Department of Health and Human Services. The purpose of participation is to study the impact on the terminally ill of provisions of the disability programs administered by the Social Security Administration. It is expected that this demonstration authority and the resulting reports which will be made on demonstration projects will provide the information necessary to enable the Congress to amend the Social Security Act so as to provide the kinds of services most appropriate for individuals who are suffering from terminal illnesses.

Voluntary Certification of Medicare Supplemental Health Insurance

(Sec. 507)

Present law.—No provision in present law.

Senate bill.—Under the Senate bill, the Secretary would be required to establish, effective January 1, 1982, a voluntary certification program for medicare supplemental policies in States that fail to establish equivalent or more stringent programs. To be certified, a policy would have to: meet minimum standards with respect to benefits, simplicity of policy language, informational material for policyholders, preexisting conditions and cancellation clauses; and be expected to pay benefits to subscribers (as estimated, for a period not to exceed one year, on the basis of actual claims experience and premiums for such policy) equal to 75 percent of premiums in the case of group policies and 60 percent in the case of individual policies. The Secretary would be required to submit a report on or before July 1, 1981, to the Committees on Finance, Ways and Means, and Interstate and Foreign Commerce which identifies those States that the Secretary finds cannot be expected to have established a qualified State regulatory program by January 1, 1982. The Federal voluntary certification program would be put into effect on January 1, 1982, in States that are so identified unless legislation to the contrary is enacted.

Upon conviction, a fine of up to $25,000 and imprisonment for up to 5 years could be assessed for: (a) furnishing false information to obtain the Secretary's certification; (b) posing as a Federal agent to sell medicare supplemental policies; (c) knowingly selling duplicative policies; and (d) selling supplemental policies by mail in States which have not approved, or are deemed not to have approved, their sale.

The Secretary, in consultation with regulatory agencies, insurers and consumers, would be required to study and submit a report to the Congress by July 1, 1981, concerning the effectiveness of various State approaches to regulation of medicare supplemental policies, and the need for standards for health insurance policies sold to the elderly which are not subject to voluntary certification. On January 1, 1982, and at least every 2 years thereafter, the Secretary would be required to report on the effectiveness of the voluntary certification program and the criminal penalties established by the bill.

Conference agreement.—The conference agreement follows the Senate bill with the following modifications. The voluntary certification program would be effective July 1, 1982. To be certified under this program, a medicare supplemental policy (including any certificate issued thereunder) would have to: (a) meet or exceed the standards with respect to medicare supplemental policies set forth in the "NAIC Model Regulation to Implement the Individual Accident and Sickness Minimum Standards Act," as amended and adopted by the National Association of Insurance Commissioners on June 6, 1979 (including the standards relating to minimum benefit provisions, preexisting condition limitations, full disclosure, and requiring a no loss cancellation clause); and (b) be expected to pay benefits to subscribers (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims ex-

perience and earned premiums for such period) equal to 75 percent of premiums in the case of group policies and 60 percent in the case of individual policies. (For purposes of determining whether the loss ratio requirement has been met under the voluntary certification program, policies issued as a result of solicitations of individuals through the mails or by mass media advertising would be deemed to be individual policies.) The Secretary would be empowered to authorize the use of an emblem by an insurer, in accordance with conditions to be specified by the Secretary, to indicate that a policy has been certified as meeting the standards and requirements of the voluntary certification program. It is expected that one such condition will be a requirement that the insurer agree to notify policyholders of the loss of certification in the event the Secretary determines that the policy no longer satisfies the standards and requirements of the voluntary certification program. It is also expected that the Secretary act in a manner consistent with the will of the State to prevent unfair competition in the use of the emblem.

The voluntary certification program would not be applicable to any policy issued in any State which is determined to have implemented under State law a regulatory program that provides for the application of standards with respect to all medicare supplemental policies (as defined in the Senate bill) that are equal to or more stringent than the standards relating to medicare supplemental policies contained in the NAIC Model Regulation as amended and adopted on June 6, 1979; and the loss ratio requirements for individual or group policies applied under the voluntary certification program. Such determinations as to whether a State's regulatory program meets these standards and requirements would be made by a Supplementary Health Insurance Panel, appointed by the President, and consisting of four Insurance Commissioners (or Superintendents) and the Secretary. On or before January 1, 1982, the Panel would prepare a report (for inclusion in the report to be submitted by the Secretary on January 1, 1982) to the appropriate Committees of the House and the Senate identifying those States that the Panel finds cannot be expected to have implemented a qualified regulatory program by July 1, 1982. The Federal voluntary certification program would be put into effect on July 1, 1982, in those States so identified by the Panel. Where a State which the Panel had expected to have implemented a qualified regulatory program by July 1, 1982, has not actually done so, the voluntary certification program would be applicable to such State until the panel determines and reports to the Secretary that the State has implemented an approved program. It is expected that the Panel will act promptly and that all determinations of the Panel would be promptly submitted to the Secretary for implementation.

Although the Panel's sole responsibility is to evaluate State regulatory programs against the test that the State program is at least equal to the NAIC standards and the prescribed loss ratio requirement, the bill includes language referring to "more stringent" standards. However, this language was not included for use as a benchmark by the Panel, but rather only to avoid the implication of any intent to encourage States to limit their regulatory programs to the minimal level. On the contrary, the conferees' intent is to assure that States are encouraged to implement such regulatory programs as they determine are

appropriate to their needs and that if a State regulatory program is at least equal to the standards and requirements provided for in the bill it would be approved by the Panel.

The delivery of a medicare supplemental policy by mail into a State which has not approved the sale of such a policy in the State would be subject to Federal criminal penalties unless such policy: (a) has been certified by the Secretary or approved by the State in which the policy is issued as meeting the standards and requirements of the voluntary certification program or the State's approved regulatory program, as the case may be, or has otherwise been deemed approved in accordance with provisions of the bill; and (b) the State into which the policy has been delivered has not specifically disapproved the policy for sale in the State.

The conferees have defined the place of issuance of a policy to be the State in which the policyholder resides in the case of an individual policy, and the State in which the holder of the master policy resides in the case of a group policy. The intent of the conferees is to allow an insurer to know which State its policy is considered to be issued in, and consequently to know whether it is issued in a State having an approved program. Nothing in this provision is intended to affect the rights of any State to regulate, in accordance with State law, policies which, under this definition, are considered to be issued in another State.

The Senate bill excludes group health policies of one or more employers or labor organizations from the definition of "medicare supplemental policy," and from the prohibition of knowingly selling a duplicative health insurance policy to a medicare-eligible individual, since such policies are not designed as supplemental policies and are sold to all age categories within the group's membership. The conferees recognize that many professional, trade and occupational associations also offer group health plans to their respective memberships. The intent is that such association, should not be treated differently than employers or labor organizations if the association: (a) is composed of individuals all of whom are actively engaged in the same profession, trade or occupation; (b) has been maintained in good faith for purposes other than the obtaining of insurance; and (c) has been in existence for at least two years prior to the date of its initial offering of such policy or plan to its members.

The Secretary's report on the results of the required study of State approaches to the regulation of supplementary policies would be submitted on January 1, 1982; and the first of the periodic reports on the effectiveness of the voluntary certification program and the criminal penalties would be due July 1, 1982.

Inclusion in Wages of FICA Taxes Paid by the Employer

Present law.—Sec. 209(f) of the Social Security Act and Sec. 3121 (a)(6) of the Internal Revenue Code provide that payment by the employer of the employee F.I.C.A. tax liability is excluded from the definition of wages for social security payroll tax and benefit purposes. Although such a payment by the employer constitutes additional compensation includable for income tax purposes, existing law specifically exempts such an amount of additional compensation from social se-

curity taxes. The net effect is that, for a given level of total compensation (wages plus employer payment of the employee share of social security tax), somewhat lower social security taxes would be payable by the employer if he pays the employee F.I.C.A. tax instead of withholding it from the employee's wages.

Senate bill.—The Senate bill required that, with respect to remuneration paid after 1980, any amounts of employee F.I.C.A. taxes paid by an employer will be considered to constitute wages for both social security tax and benefit purposes but that this change will not apply in the case of payments made on behalf of employees of (1) small businesses (as used in the administration of section 7(a) of the Small Business Act), (2) of State and local governments, (3) of nonprofit organizations, and (4) persons employed as domestics.

Conference agreement.—The conferees have agreed to delete this provision of the Senate bill. While the Senate amendment would narrow the scope of the present law exclusion from wages, the conferees are concerned that its enactment would lend countenance to expanded utilization of the remaining exclusion. The conferees believe that this is an important issue in its own right, deserving further study and consideration by the Congress. The result of the conferees' decision is that present law remains in force.

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Managers on the Part of the Senate.

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Finder's Aid

P.L. 96-272 (94 Stat. 500) Approved June 17, 1980
"Adoption Assistance and Child Welfare Act of 1980"

SSAct Section and Subject	P.L. Section	94 Stat.	H. Rep. 96 - 136	H. Rep. 96 - 136 Pt. 2	S. Rep. 96 - 336	H.C. Rep. 96 - 900
402(a)(8)(D) Incentive to Report Earnings Under AFDC Programs	302(a)(1)	528	--	--	89	65
402(a)(8)(E)(new) Incentive to Report Earnings Under AFDC Programs	302(a)(2)	528	--	--	89	65
402(a)(20) Establish New IV-E Program (Foster Care & Adoption Assistance)	101(a)(3)(A)	512	6-7	--	10-17	43
408(a)(1) Federal Payment For Dependent Child Voluntarily Placed in Foster Care	102(b)(1)(A)	515	6-7	--	10-19	50-51
408(a)(3) Federal Payment For Dependent Child Voluntarily Placed in Foster Care	102(b)(1)(B)	515	6-7	--	10-19	50-51
408(a)(4)(A) Federal Payment For Dependent Child Voluntarily Placed in Foster Care	102(b)(1)(C)	515	6-7	--	10-19	50-51
408(a)(4)(B)(ii) Federal Payment For Dependent Child Voluntarily Placed in Foster Care	102(b)(1)(D)	515	6-7	--	10-19	50-51
408(end)(new) Federal Payment For Dependent Child Voluntarily Placed in Foster Care	102(b)(2)	515	6-7	--	10-19	50-51
408[last ¶] Federal Definitions of Foster Care	101(a)(5)(A)	513	51-54	--	14-17	50
412 Prorating of Shelter Allowance	303	528	--	--	90-91	65-66
420 Child Welfare Services (Appropriation)	103(a)	516	40-42	1-2	17-19	56-57
421 Child Welfare Services (Allotments to States)	103(a)	516	40-42	1-2	17-19	56-57
422 Child Welfare Services (State Plans)	103(a)	517	4-6, 28	1-2	17-19	56-57

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424 Child Welfare Services (Reallotment)	103(a)	519	15	--	32	59
425 Child Welfare Services (Definitions)	103(a)	519	42-43	--	--	57-58
427(new) Child Welfare Services (Requirements for added Federal Funding)	103(b)	519	40-51	--	17-19	56-57
428(new) Child Welfare Services (Direct Payment to Indian Tribal Organizations)	103(b)	520	--	--	19	59
452(a)(10) Child Support--Federal Funding Non-AFDC	301(b)	527	--	--	76-78	65
458[Heading] Child Support--State Incentives	307(a)	531	--	--	76-78	67
458(a) Child Support--State Incentives	307(b)	531	--	--	76-78	67
458(c)[new] Child Support--State Incentives	307(c)	531	--	--	76-78	67
470[new] Foster Care and Adoption Assistance	101(a)(1)	501	--	--	10-17	43
471[new] Foster Care and Adoption Assistance (State Plans)	101(a)(1)	501	--	--	10-17	43-55
472[new] Foster Care and Adoption Assistance (Foster Care Maintenance Payments Program)	101(a)(1)	503	51-56	--	10-17	43-55
472(a)(1) Foster Care-- Voluntary Placement	102(a)(1)(A)	513	51-53	--	10-19	50-51
472(a)(3) Foster Care-- Voluntary Placement	102(a)(1)(B)	513	51-53	--	10-19	50-51
472(a)(4)(A) Foster Care-- Voluntary Placement	102(a)(1)(C)	513	51-53	--	10-19	50-51

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472(d) [redesignated (h)] Foster Care-- Voluntary Placement	102(a)(2)	514	51-53	--	10-19	50-51
472(d)[new] Foster Care-- Voluntary Placement	102(a)(2)	514	51-53	--	10-19	50-51
472(e)[new] Foster Care-- Voluntary Placement	102(a)(2)	514	51-53	--	10-19	50-51
472(f)[new] Foster Care-- Voluntary Placement	102(a)(2)	514	51-53	--	10-19	50-51
472(g)[new] Foster Care-- Voluntary Placement	102(a)(2)	514	51-53	--	10-19	50-51
473[new] Adoption Assistance Program	101(a)(1)	504	51-56	--	10-14	51-55
473(a)(1)(A)(i) Adoption Assistance Program	102(a)(3)(A)	514	51-56	--	10-14	51-55
473(a)(1)(B)(i) Adoption Assistance Program	102(a)(3)(B)	514	51-56	--	10-14	51-55
473(a)(1)(B)(ii) Adoption Assistance Program	102(a)(3)(C)	514	51-56	--	10-14	51-55
474[new] Payments to States; Allotments to States	101(a)(1)	506	51-56	--	10-17	43-55
475[new] Definitions	101(a)(1)	510	51-56	--	10-17	43-55
475(1) Definitions	102(a)(4)	514	51-56	--	10-17	43-55
476[new] Technical Assistance; Data Collection and Evaluation	101(a)(1)	511	--	--	10-17	43-55
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1108(a)(1)(E) Public Assistance Payments to Territorial Jurisdictions	305(a)(1)	529	39-40	--	92-96	66
1108(a)(1)(F) Public Assistance Payments to Territorial Jurisdictions	305(a)(2)	530	39-40	--	92-96	66
1108(a)(2)(E) Public Assistance Payments to Territorial Jurisdictions	305(a)(1)	529	39-40	--	92-96	66
1108(a)(2)(F) Public Assistance Payments to Territorial Jurisdictions	305(a)(2)	530	39-40	--	92-96	66
1108(a)(3)(E) Public Assistance Payments to Territorial Jurisdictions	305(a)(1)	529	39-40	--	92-96	66
1108(a)(3)(F) Public Assistance Payments to Territorial Jurisdictions	305(a)(2)	530	39-40	--	92-96	66
1118 Public Assistance Payments to Territorial Jurisdictions	305(c)	530	39-40	--	92-96	66
1132[new] Claims Filing Periods	306(a)	530	15	--	96	66-67
1133[new] Continuing Medicaid Eligibility for Certain Veterans	310(a)(1)	532	--	--	--	68-69
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1862(d)(4)[new] Exchange of Information Re Certain Medicare/ Medicaid Providers	308(a)	531	--	--	--	67-68
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BEST DOCUMENT AVAILABLE

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1902(a)(39) Exchange of Information Re Certain Medicare/ Medicaid Providers	308(c)(1)	531	--	--	--	67-68
1902(a)(40) Exchange of Information Re Certain Medicare/ Medicaid Providers	308(c)(2)	531	--	--	--	67-68
1902(a)(41)[new] Exchange of Information Re Certain Medicare/ Medicaid Providers	308(c)(3)	531	--	--	--	67-68
2001 [last sentence] Social Services Funding For Territories	207(b)	526	39-40	--	73	63
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2002(a)(2)(B) [new] Title XX Ceilings on Funds	201(b)	522	3	--	59-61	60
2002(a)(2)(C) [redesignated as 2002(a)(2)(E)] Title XX Ceilings on Funds	201(c)(1)	522	3	--	59-61	60
2002(a)(2)(C) [new] Social Services Funding For Territories	207(a)	525	39-40	--	73	63
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PUBLIC LAW 96-272—JUNE 17, 1980

ADOPTION ASSISTANCE AND CHILD WELFARE ACT OF 1980

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Public Law 96-272
96th Congress

An Act

June 17, 1980
[H.R. 3434]

To establish a program of adoption assistance, to strengthen the program of foster care assistance for needy and dependent children, to improve the child welfare, social services, and aid to families with dependent children programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Adoption Assistance and Child Welfare Act of 1980.

SHORT TITLE

42 USC 1305 note

SECTION 1. This Act, with the following table of contents, may be cited as the "Adoption Assistance and Child Welfare Act of 1980".

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TITLE I—FOSTER CARE AND ADOPTION ASSISTANCE

FEDERAL PAYMENTS FOR FOSTER CARE AND ADOPTION ASSISTANCE

SEC. 101. (a)(1) Title IV of the Social Security Act is amended by adding at the end thereof the following new part:

"PART E—FEDERAL PAYMENTS FOR FOSTER CARE AND ADOPTION ASSISTANCE

"PURPOSE: APPROPRIATION

"SEC. 470. For the purpose of enabling each State to provide, in appropriate cases, foster care and adoption assistance for children who otherwise would be eligible for assistance under the State's plan approved under part A (or, in the case of adoption assistance, would be eligible for benefits under title XVI), there are authorized to be appropriated for each fiscal year (commencing with the fiscal year which begins October 1, 1980) such sums as may be necessary to carry out the provisions of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans under this part. 42 USC 670. 42 USC 601. 42 USC 1381.

"STATE PLAN FOR FOSTER CARE AND ADOPTION ASSISTANCE

"SEC. 471. (a) In order for a State to be eligible for payments under this part, it shall have a plan approved by the Secretary which— 42 USC 671.

"(1) provides for foster care maintenance payments in accordance with section 472 and for adoption assistance payments in accordance with section 473;

"(2) provides that the State agency responsible for administering the program authorized by part B of this title shall administer, or supervise the administration of, the program authorized by this part; *Post*, p. 516.

"(3) provides that the plan shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

"(4) provides that the State shall assure that the programs at the local level assisted under this part will be coordinated with the programs at the State or local level assisted under parts A and B of this title, under title XX of this Act, and under any other appropriate provision of Federal law; 42 USC 601, *post*, p. 516, 42 USC 1397.

"(5) provides that the State will, in the administration of its programs under this part, use such methods relating to the establishment and maintenance of personnel standards on a merit basis as are found by the Secretary to be necessary for the proper and efficient operation of the programs, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods;

"(6) provides that the State agency referred to in paragraph (2) (hereinafter in this part referred to as the 'State agency') will make such reports, in such form and containing such information as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find "State agency."

such year) who, at any time during such year, will remain in foster care after having been in such care for a period in excess of twenty-four months, and (B) a description of the steps which will be taken by the State to achieve such goals;

"(15) effective October 1, 1983, provides that, in each case, reasonable efforts will be made (A) prior to the placement of a child in foster care, to prevent or eliminate the need for removal of the child from his home, and (B) to make it possible for the child to return to his home; and

"(16) provides for the development of a case plan (as defined in section 475(1)) for each child receiving foster care maintenance payments under the State plan and provides for a case review system which meets the requirements described in section 475(5)(B) with respect to each such child. Case plan and case review system.

"(b) The Secretary shall approve any plan which complies with the provisions of subsection (a) of this section. However, in any case in which the Secretary finds, after reasonable notice and opportunity for a hearing, that a State plan which has been approved by the Secretary no longer complies with the provisions of subsection (a), or that in the administration of the plan there is a substantial failure to comply with the provisions of the plan, the Secretary shall notify the State that further payments will not be made to the State under this part, or that such payments will be made to the State but reduced by an amount which the Secretary determines appropriate, until the Secretary is satisfied that there is no longer any such failure to comply, and until he is so satisfied he shall make no further payments to the State, or shall reduce such payments by the amount specified in his notification to the State. Plan approval.

"FOSTER CARE MAINTENANCE PAYMENTS PROGRAM

"SEC. 472. (a) Each State with a plan approved under this part shall make foster care maintenance payments (as defined in section 475(4)) under this part with respect to a child who would meet the requirements of section 406(a) or of section 407 but for his removal from the home of a relative (specified in section 406(a)), if— 42 USC 672. *Post*, p. 513. 42 USC 606, 607.

"(1) the removal from the home was the result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child and (effective October 1, 1983) that reasonable efforts of the type described in section 471(a)(15) have been made;

"(2) such child's placement and care are the responsibility of (A) the State agency administering the State plan approved under section 471, or (B) any other public agency with whom the State agency administering or supervising the administration of the State plan approved under section 471 has made an agreement which is still in effect;

"(3) such child has been placed in a foster family home or child-care institution as a result of a determination referred to in paragraph (1); and

"(4) such child—

"(A) received aid under the State plan approved under section 402 in or for the month in which court proceedings leading to the removal of such child from the home were initiated, or 42 USC 602.

"(B)(i) would have received such aid in or for such month if application had been made therefor, or (ii) had been living

42 USC 606

with a relative specified in section 406(a) within six months prior to the month in which such proceedings were initiated, and would have received such aid in or for such month if in such month he had been living with such a relative and application therefor had been made.

"(b) Foster care maintenance payments may be made under this part only on behalf of a child described in subsection (a) of this section who is—

"(1) in the foster family home of an individual, whether the payments therefor are made to such individual or to a public or nonprofit private child-placement or child-care agency, or

"(2) in a child-care institution, whether the payments therefor are made to such institution or to a public or nonprofit private child-placement or child-care agency, which payments shall be limited so as to include in such payments only those items which are included in the term 'foster care maintenance payments' (as defined in section 475(4)).

"Foster family home"

"(c) For the purposes of this part, (1) the term 'foster family home' means a foster family home for children which is licensed by the State in which it is situated or has been approved, by the agency of such State having responsibility for licensing homes of this type, as meeting the standards established for such licensing; and (2) the term 'child-care institution' means a nonprofit private child-care institution, or a public child-care institution which accommodates no more than twenty-five children, which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing, but the term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.

"Child-care institution"

42 USC 1396, 1397

42 USC 606

42 USC 601

"(d) For purposes of titles XIX and XX, any child with respect to whom foster care maintenance payments are made under this section shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of this title.

"ADOPTION ASSISTANCE PROGRAM

42 USC 673
Post, p. 514

"SEC. 473. (a)(1) Each State with a plan approved under this part shall, directly through the State agency or through another public or nonprofit private agency, make adoption assistance payments pursuant to an adoption assistance agreement in amounts determined under paragraph (2) of this subsection to parents who, after the effective date of this section, adopt a child who—

42 USC 606, 607

"(A)(i) at the time adoption proceedings were initiated, met the requirements of section 406(a) or section 407 or would have met such requirements except for his removal from the home of a relative (specified in section 406(a)) as a result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child, or

42 USC 1381

"(ii) meets all of the requirements of title XVI with respect to eligibility for supplemental security income benefits,

42 USC 602

"(B)(i) received aid under the State plan approved under section 402 in or for the month in which court proceedings leading to the removal of such child from the home were initiated, or

reasonable to conclude that such child cannot be placed with adoptive parents without providing adoption assistance, and (B) that, except where it would be against the best interests of the child because of such factors as the existence of significant emotional ties with prospective adoptive parents while in the care of such parents as a foster child, a reasonable, but unsuccessful, effort has been made to place the child with appropriate adoptive parents without providing adoption assistance under this section.

"PAYMENTS TO STATES; ALLOTMENTS TO STATES

42 USC 673

"SEC. 474. (a) For each quarter beginning after September 30, 1980, each State which has a plan approved under this part (subject to the limitations imposed by subsection (b)) shall be entitled to a payment equal to the sum of—

42 USC 1396d

"(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b) of this Act) of the total amount expended during such quarter as foster care maintenance payments under section 472 for children in foster family homes or child-care institutions; plus

"(2) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b) of this Act) of the total amount expended during such quarter as adoption assistance payments under section 473 pursuant to adoption assistance agreements; plus

"(3) an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan—

"(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision, and

"(B) one-half of the remainder of such expenditures.

"(b)(1) Notwithstanding the provisions of subsections (a)(1) and (a)(3), the aggregate of the sums payable thereunder to any State (other than a State subject to limitation under section 1108(a)) with respect to expenditures relating to foster care, for the calendar quarters in any of the fiscal years 1981 through 1984 in which the conditions set forth in paragraph (2) are met, shall not exceed the State's allotment for such year.

42 USC 1308
Post, pp. 520, 529, 530

"(2)(A) The limitation in paragraph (1) shall apply—

"(i) with respect to fiscal year 1981, only if the amount appropriated under section 420 for such fiscal year is equal to or greater than $163,550,000;

42 USC 620

"(ii) with respect to fiscal year 1982, only if the amount appropriated under section 420 for such fiscal year is equal to or greater than $220,000,000;

"(iii) with respect to fiscal year 1983, only if the amount appropriated under section 420 for such fiscal year is equal to $266,000,000; and

"(iv) with respect to fiscal year 1984, only if the amount appropriated under section 420 for such fiscal year is equal to $266,000,000.

42 USC 620

"(B) If, for each of any two consecutive fiscal years, there is appropriated under section 420 a sum equal to $266,000,000, no State may claim any amount under the provisions of this subsection as reimbursement for expenditures for any succeeding fiscal year pursuant to part B of this title unless such State has met the requirements set forth in section 427(b).

Post, p. 516
Post, p. 519

"(C) If, for each of any two fiscal years during which the limitation under subsection (b)(1) is not in effect, the total amount claimed by a State as reimbursement for expenditures pursuant to part B under this subsection and under section 420 equals the amount which would be allotted to such State for such fiscal year under part B if the amount appropriated under section 420 were $266,000,000, such State may not claim any amount under the provisions of paragraph (2) as reimbursement for expenditures for any succeeding fiscal year pursuant to part B of this title unless such State has met the requirements set forth in section 427(b).

"DEFINITIONS

42 USC 675.
Ante, p. 501; post, 516

"SEC. 475. As used in this part or part B of this title:

"(1) The term 'case plan' means a written document which includes at least the following: A description of the type of home or institution in which a child is to be placed, including a discussion of the appropriateness of the placement and how the agency which is responsible for the child plans to carry out the judicial determination made with respect to the child in accordance with section 472(a)(1); and a plan for assuring that the child receives proper care and that services are provided to the parents, child, and foster parents in order to improve the conditions in the parents' home, facilitate return of the child to his own home or the permanent placement of the child, and address the needs of the child while in foster care, including a discussion of the appropriateness of the services that have been provided to the child under the plan.

"(2) The term 'parents' means biological or adoptive parents or legal guardians, as determined by applicable State law.

"(3) The term 'adoption assistance agreement' means a written agreement, binding on the parties to the agreement, between the State agency, other relevant agencies, and the prospective adoptive parents of a minor child which at a minimum (A) specifies the amounts of the adoption assistance payments and any additional services and assistance which are to be provided as part of such agreement, and (B) stipulates that the agreement shall remain in effect regardless of the State of which the adoptive parents are residents at any given time. The agreement shall contain provisions for the protection (under an interstate compact approved by the Secretary or otherwise) of the interests of the child in cases where the adoptive parents and child move to another State while the agreement is effective.

"(4) The term 'foster care maintenance payments' means payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation. In the case of institutional care, such term shall include the reasonable costs of administration and operation of such institution as are necessarily required to provide the items described in the preceding sentence.

"(5) The term 'case review system' means a procedure for assuring that—

"(A) each child has a case plan designed to achieve placement in the least restrictive (most family like) setting available and in close proximity to the parents' home, consistent with the best interest and special needs of the child,

"(B) the status of each child is reviewed periodically but no less frequently than once every six months by either a court or by administrative review (as defined in paragraph (6)) in order to determine the continuing necessity for and appropriateness of the placement, the extent of compliance with the case plan, and the extent of progress which has been made toward alleviating or mitigating the causes necessitating placement in foster care, and to project a likely date by which the child may be returned to the home or placed for adoption or legal guardianship, and

"(C) with respect to each such child, procedural safeguards will be applied, among other things, to assure each child in foster care under the supervision of the State of a dispositional hearing to be held, in a family or juvenile court or another court (including a tribal court) of competent jurisdiction, or by an administrative body appointed or approved by the court, no later than eighteen months after the original placement (and periodically thereafter during the continuation of foster care), which hearing shall determine the future status of the child (including, but not limited to, whether the child should be returned to the parent, should be continued in foster care for a specified period, should be placed for adoption, or should (because of the child's special needs or circumstances) be continued in foster care on a permanent or long-term basis); and procedural safeguards shall also be applied with respect to parental rights pertaining to the removal of the child from the home of his parents, to a change in the child's placement, and to any determination affecting visitation privileges of parents.

"(6) The term 'administrative review' means a review open to the participation of the parents of the child, conducted by a panel of appropriate persons at least one of whom is not responsible for the case management of, or the delivery of services to, either the child or the parents who are the subject of the review.

"TECHNICAL ASSISTANCE; DATA COLLECTION AND EVALUATION

"SEC. 476. (a) The Secretary may provide technical assistance to the States to assist them to develop the programs authorized under this part and shall periodically (1) evaluate the programs authorized under this part and part B of this title and (2) collect and publish data pertaining to the incidence and characteristics of foster care and adoptions in this country. 42 USC 676. *Ante*, p. 501, *post*, p. 516.

"(b) Each State shall submit statistical reports as the Secretary may require with respect to children for whom payments are made under this part containing information with respect to such children including legal status, demographic characteristics, location, and length of any stay in foster care.". Statistical reports to Secretary.

Repeal.
42 USC 608.

(2)(A) Effective with respect to expenditures made after September 30, 1980, section 408 of the Social Security Act is, subject to subparagraph (B), repealed.

42 USC 608 note.

(B) The repeal made by subparagraph (A) shall not be applicable in the case of any State for any quarter prior to the first quarter, which begins after September 30, 1980, in which such State has in effect a State plan approved under part E of the Social Security Act, or (if earlier) such repeal shall be effective with respect to expenditures made after September 30, 1982. During any period with respect to which the repeal made by subparagraph (A) is not applicable in the case of a State and during which a limitation is in effect under section 474(b)(1) of the Social Security Act, the aggregate of the sums payable to the State, under the State's plan approved under part A of title IV of such Act, with respect to expenditures (including administrative expenditures as determined by the Secretary of Health, Education, and Welfare) authorized or incurred by reason of the provisions of section 408 of such Act shall not exceed the amount of the allotment which such State would have had for such period under section 474(b) if such State had had an approved plan under part E of such title IV. Any amount which would have been available to such State from its allotment for any period with respect which such repeal is not applicable in the case of a State (whether or not a limitation is in effect under section 474(b)(1) of such Act) under section 474(b) of the Social Security Act (if such State had had an approved plan under part E of title IV of such Act) which the State does not claim as reimbursement with respect to expenditures (including administrative expenditures as determined by the Secretary) authorized or incurred by reason of the provisions of section 408 of such Act, may be claimed by the State as reimbursement for expenditures in such period pursuant to part B of title IV of such Act in the same manner as amounts available to States from allotments under section 474(b) of such Act, and not claimed as reimbursement under part E of title IV of such Act, are authorized to be claimed under section 474(c) of such Act.

Ante, p. 501.

Supra.

Post, p. 516.

42 USC 602.

(3)(A) Section 402(a)(20) of such Act is amended to read as follows:

"(20) provide that the State has in effect a State plan for foster care and adoption assistance approved under part E of this title;".

Ante, p. 501.

Effective date.
42 USC 602 note.

(B) The amendment made by subparagraph (A) shall become effective with respect to any State at the same time as the repeal of section 408 becomes effective with respect to such State under the provisions of paragraph (2) of this subsection.

Effective date.
42 USC [illegible] note.
Ante, p. [illegible].

(4)(A) Clause (B) of the first sentence of section 475(3) of the Social Security Act (as added by subsection (a) of this section) shall be effective with respect to adoption assistance agreements entered into on or after October 1, 1983.

Interstate compacts.
42 USC 673a.

(B) The Secretary of Health, Education, and Welfare shall take all possible steps to encourage and assist the various States to enter into interstate compacts (which are hereby approved by the Congress) under which the interests of any adopted child with respect to whom an adoption assistance agreement has been entered into by a State under section 473 of the Social Security Act will be adequately protected, on a reasonable and equitable basis which is approved by the Secretary, if and when the child and his or her adoptive parent (or parents) move to another State.

Ante, p. 504.

(5)(A) Subject to the repeal provided under paragraph (2), the last paragraph of section 408 of the Social Security Act is amended to read as follows:

Ante, p. 512.

"For the purposes of this section, the term 'foster family home' means a foster family home for children which is licensed by the State in which it is situated or has been approved, by the agency of such State having responsibility for licensing homes of this type, as meeting the standards established for such licensing; and the term 'child-care institution' means a nonprofit private child-care institution, or a public child-care institution which accommodates no more than twenty-five children, which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing; but the term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.".

"Foster family home."

"Child-care institution."

(B) The amendment made by subparagraph (A) shall be effective with respect to expenditures made on or after the date of the enactment of this Act.

Effective date.
42 USC 608 note.

(b)(1) The Secretary of Health, Education, and Welfare shall conduct a study of programs of foster care and adoption assistance established under part IV-E of the Social Security Act (as added by subsection (a) of this section), and shall submit to the Congress, not later than October 1, 1983, a full and complete report thereon, together with his recommendations as to (A) whether such part IV-E should be continued, and if so, (B) the changes (if any) which should be made in such part IV-E.

Report to Congress.
42 USC 670 note.

Ante, p. 501.

(2) Such report shall include, but not be limited to, the following:

(A) a determination as to (i) the extent of reduction that has occurred in the duration of foster care under such programs, (ii) the extent to which such programs of adoption assistance have resulted in an increase in the adoption of children who otherwise would have remained in foster care under State plans approved under title IV-A or IV-E of the Social Security Act, and (iii) the extent to which the availability of Federal funding for adoption assistance under title IV-E of such Act has resulted in States' initiating or expanding programs for adoption assistance, and

42 USC 601, *ante*, p. 501.

(B) specific legislative recommendations for ways to bring about further reduction in the duration of foster care for children.

FEDERAL PAYMENTS FOR DEPENDENT CHILDREN VOLUNTARILY PLACED IN FOSTER CARE

SEC. 102. (a)(1) Effective with respect to expenditures made after September 30, 1980, and before October 1, 1983, section 472(a) of the Social Security Act (as added by section 101 of this Act) is amended—

Ante, p. 503.

(A) by inserting "occurred pursuant to a voluntary placement agreement entered into by the child's parent or legal guardian, or" after "removal from the home" in paragraph (1);

(B) by striking out "a determination" in paragraph (3) and inserting in lieu thereof "the voluntary placement agreement or judicial determination";

(C) by inserting "such agreement was entered into or" after "the month in which" in paragraph (4)(A); and

(D) by inserting "such agreement was entered into or" after "the month in which" in paragraph (4)(B)(ii).

Ante, p. 503

(2) Section 472 of such Act (as so added) is further amended by redesignating subsection (d) as subsection (h), and by inserting after subsection (c) the following new subsections:

"(d) Notwithstanding any other provision of this title, Federal payments may be made under this part with respect to amounts expended by any State as foster care maintenance payments under this section, in the case of children removed from their homes pursuant to voluntary placement agreements as described in subsection (a), only if (at the time such amounts were expended) the State has fulfilled all of the requirements of section 427(b).

Post, p. 519

"(e) No Federal payment may be made under this part with respect to amounts expended by any State as foster care maintenance payments under this section, in the case of any child who was removed from his or her home pursuant to a voluntary placement agreement as described in subsection (a) and has remained in voluntary placement for a period in excess of 180 days, unless there has been a judicial determination by a court of competent jurisdiction (within the first 180 days of such placement) to the effect that such placement is in the best interests of the child.

Ante, p. 501, *post*, 516.

"Voluntary placement"

"Voluntary placement agreement"

"(f) For the purposes of this part and part B of this title, (1) the term 'voluntary placement' means an out-of-home placement of a minor, by or with participation of a State agency, after the parents or guardians of the minor have requested the assistance of the agency and signed a voluntary placement agreement; and (2) the term 'voluntary placement agreement' means a written agreement, binding on the parties to the agreement, between the State agency, any other agency acting on its behalf, and the parents or guardians of a minor child which specifies, at a minimum, the legal status of the child and the rights and obligations of the parents or guardians, the child, and the agency while the child is in placement.

"(g) In any case where—

"(1) the placement of a minor child in foster care occurred pursuant to a voluntary placement agreement entered into by the parents or guardians of such child as provided in subsection (a), and

"(2) such parents or guardians request (in such manner and form as the Secretary may prescribe) that the child be returned to their home or to the home of a relative,

the voluntary placement agreement shall be deemed to be revoked unless the State agency opposes such request and obtains a judicial determination, by a court of competent jurisdiction, that the return of the child to such home would be contrary to the child's best interests.".

Ante, p. 504

(3) Section 473(a)(1) of such Act (as so added) is amended—

(A) by inserting ", either pursuant to a voluntary placement agreement with respect to which Federal payments are provided under section 474 (or 403) or" immediately before "as a result of a judicial determination" in subparagraph (A)(i);

Ante, p. 506, 42 USC 603

(B) by inserting "such agreement was entered into or" after "the month in which" in subparagraph (B)(i); and

(C) by inserting "such agreement was entered into or" after "the month in which" in subparagraph (B)(ii).

Ante, p. 510

(4) Section 475(1) of such Act (as so added) is amended by inserting "voluntary placement agreement entered into or" before "judicial determination made".

(b)(1) Effective with respect to expenditures made after September 30, 1979 (but subject to the repeal provided under section 101(a)(2) (A) and (B)), section 408(a) of the Social Security Act is amended— *Ante*, p. 512.

(A) by inserting "pursuant to a voluntary placement agreement entered into by the child's parent or legal guardian, or" after "(specified in such section 406(a))" in clause (1); 42 USC 606.

(B) by striking out "such determination" in clause (3) and inserting in lieu thereof "such voluntary placement agreement or judicial determination";

(C) by inserting "such agreement was entered into or" after "the month in which" in clause (4)(A); and

(D) by inserting "such agreement was entered into or" after "the month in which" in clause (4)(B)(ii).

(2) Section 408 of such Act is further amended by adding at the end thereof the following new paragraph:

"For the purposes of this section, the provisions of subsections (d), (e), (f), and (g) of section 472 shall apply.". *Ante*, p. 503.

(c) The amendments made by subsections (a) and (b) shall be effective only with respect to expenditures made after September 30, 1979, and before October 1, 1983; and from and after October 1, 1983, the provisions of law amended by such subsections shall read as they would if this section had not been enacted. Effective date. 42 USC 672 note, 608, 672, 673, 675

(d)(1) For purposes of section 472 of the Social Security Act, a child who was voluntarily removed from the home of a relative and who had a judicial determination prior to October 1, 1978, to the effect that continuation therein would be contrary to the welfare of such child, shall be deemed to have been so removed as a result of such judicial determination if, and from the date that, a case plan and a review meeting the requirements of section 471(a)(16) of such Act have been made with respect to such child and such child is determined to be in need of foster care as a result of such review. In the case of any child described in the preceding sentence, for purposes of section 472(a)(4) of such Act, the date of the voluntary removal shall be deemed to be the date on which court proceedings are initiated which led to such removal. 42 USC 672 note. *Ante*, p. 501.

(2) For purposes of section 408 of the Social Security Act (but subject to the repeal provided under section 101(a)(2) (A) and (B)), in any case where a child was voluntarily removed from the home of a relative prior to October 1, 1979, and a judicial determination was made (prior to October 1, 1978) to the effect that continuation in such home would have been contrary to the child's welfare— 42 USC 608 note. *Ante*, p. 512.

(A) such child shall be deemed to have been so removed as a result of a judicial determination to the effect that continuation in such home would be contrary to the welfare of such child, and

(B) Federal financial participation under the applicable State plan approved under section 402 of the Social Security Act for quarters beginning prior to October 1, 1979, shall not be denied with respect to aid furnished under such plan to or on behalf of such child. 42 USC 602.

For purposes of subsection (a)(4) of such section 408, the date of such child's voluntary removal shall be deemed to be the date on which court proceedings were initiated which led to such removal. *Ante*, p. 512.

(e) The Secretary of Health, Education, and Welfare, within three months after the close of each fiscal year with respect to which the amendments made by this section are in effect, shall submit to the Congress a full and complete report on the number of children placed in foster care pursuant to voluntary placement agreements under Report to Congress. 42 USC 672 note

Ante, pp. 512, 513.

sections 408 and 472 of the Social Security Act and on the reasons for such placements together with a description of the extent to which such placements have contributed to the achievement of the objectives of this title, including such recommendations as he may deem appropriate with respect to the continuation (in such section 472) of authority to make Federal payments for dependent children voluntarily placed in foster care.

CHILD WELFARE SERVICES

SEC. 103. (a) Part B of title IV of the Social Security Act is amended (subject to subsection (c) of this section) by striking out all that precedes section 426 and inserting in lieu thereof the following:

"PART B—CHILD WELFARE SERVICES

"APPROPRIATION

42 USC 620.

"SEC. 420. (a) For the purpose of enabling the United States, through the Secretary, to cooperate with State public welfare agencies in establishing, extending, and strengthening child welfare services, there is authorized to be appropriated for each fiscal year the sum of $266,000,000.

"(b) Funds appropriated for any fiscal year pursuant to the authorization contained in subsection (a) shall be included in the appropriation Act (or supplemental appropriation Act) for the fiscal year preceding the fiscal year for which such funds are available for obligation. In order to effect a transition to this method of timing appropriation action, the preceding sentence, shall apply notwithstanding the fact that its initial application will result in the enactment in the same year (whether in the same appropriation Act or otherwise) of two separate appropriations, one for the then current fiscal year and one for the succeeding fiscal year.

"ALLOTMENTS TO STATES

42 USC 621.

"SEC. 421. (a) The sum appropriated pursuant to section 420 for each fiscal year shall be allotted by the Secretary for use by cooperating State public welfare agencies which have plans developed jointly by the State agency and the Secretary as follows: He shall first allot $70,000 to each State, and shall then allot to each State an amount which bears the same ratio to the remainder of such sum as the product of (1) the population of the State under the age of twenty-one and (2) the allotment percentage of the State (as determined under this section) bears to the sum of the corresponding products of all the States.

Allotment percentage.

"(b) The 'allotment percentage' for any State shall be 100 per centum less the State percentage; and the State percentage shall be the percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States; except that (1) the allotment percentage shall in no case be less than 30 per centum or more than 70 per centum, and (2) the allotment percentage shall be 70 per centum in the case of Puerto Rico, the Virgin Islands, and Guam.

Promulgation by Secretary.

"(c) The allotment percentage for each State shall be promulgated by the Secretary between October 1 and November 30 of each even-numbered year, on the basis of the average per capita income of each State and of the United States for the three most recent calendar

years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning October 1 next succeeding such promulgation.

"(d) For purposes of this section, the term 'United States' means the fifty States and the District of Columbia. "United States."

"STATE PLANS FOR CHILD WELFARE SERVICES

"SEC. 422. (a) In order to be eligible for payment under this part, a State must have a plan for child welfare services which has been developed jointly by the Secretary and the State agency designated pursuant to subsection (b)(1), and which meets the requirements of subsection (b). 42 USC 622. *Post*, p. 521.

"(b) Each plan for child welfare services under this part shall—

"(1) provide that (A) the individual or agency designated pursuant to section 2003(d)(1)(C) to administer or supervise the administration of the State's services program will administer or supervise the administration of the plan (except as otherwise provided in section 103(d) of the Adoption Assistance and Child Welfare Act of 1980), and (B) to the extent that child welfare services are furnished by the staff of the State agency or local agency administering the plan, a single organizational unit in such State or local agency, as the case may be, will be responsible for furnishing such child welfare services; 42 USC 1397b. *Ante*, p. 516.

"(2) provide for coordination between the services provided for children under the plan and the services and assistance provided under title XX, under the State plan approved under part A of this title, under the State plan approved under part E of this title, and under other State programs having a relationship to the program under this part, with a view to provision of welfare and related services which will best promote the welfare of such children and their families; 42 USC 1397. 42 USC 601. *Ante*, p. 501.

"(3) provide that the standards and requirements imposed with respect to child day care under title XX shall apply with respect to day care services under this part, except insofar as eligibility for such services is involved;

"(4) provide for the training and effective use of paid paraprofessional staff, with particular emphasis on the full-time or part-time employment of persons of low income, as community service aides, in the administration of the plan, and for the use of nonpaid or partially paid volunteers in providing services and in assisting any advisory committees established by the State agency; Paraprofessionals and volunteers.

"(5) contain a description of the services to be provided and specify the geographic areas where such services will be available;

"(6) contain a description of the steps which the State will take to provide child welfare services and to make progress in—

"(A) covering additional political subdivisions,

"(B) reaching additional children in need of services, and

"(C) expanding and strengthening the range of existing services and developing new types of services,

along with a description of the State's child welfare services staff development and training plans;

"(7) provide, in the development of services for children, for utilization of the facilities and experience of voluntary agencies Voluntary agencies, utilization.

in accordance with State and local programs and arrangements, as authorized by the State; and

"(8) provide that the agency administering or supervising the administration of the plan will furnish such reports, containing such information, and participate in such evaluations, as the Secretary may require.

'PAYMENT TO STATES

42 USC 623.

"SEC. 423. (a) From the sums appropriated therefor and the allotment under this part, subject to the conditions set forth in this section and in section 427, the Secretary shall from time to time pay to each State that has a plan developed in accordance with section 422 an amount equal to 75 per centum of the total sum expended under the plan (including the cost of administration of the plan) in meeting the costs of State, district, county, or other local child welfare services.

Computation method.

"(b) The method of computing and making payments under this section shall be as follows:

"(1) The Secretary shall, prior to the beginning of each period for which a payment is to be made, estimate the amount to be paid to the State for such period under the provisions of this section.

"(2) From the allotment available therefor, the Secretary shall pay the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which he finds that his estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid to the State for such prior period under this section.

"(c)(1) No payment may be made to a State under this part, for any fiscal year beginning after September 30, 1979, with respect to State expenditures made for (A) child day care necessary solely because of the employment, or training to prepare for employment, of a parent or other relative with whom the child involved is living, (B) foster care maintenance payments, and (C) adoption assistance payments, to the extent that the Federal payment with respect to those expenditures would exceed the total amount of the Federal payment under this part for fiscal year 1979.

"(2) Expenditures made by a State for any fiscal year which begins after September 30, 1979, for foster care maintenance payments shall be treated for purposes of making Federal payments under this part with respect to expenditures for child welfare services, as if such foster care maintenance payments constituted child welfare services of a type to which the limitation imposed by paragraph (1) does not apply; except that the amount payable to the State with respect to expenditures made for other child welfare services and for foster care maintenance payments during any such year shall not exceed 100 per centum of the amount of the expenditures made for child welfare services for which payment may be made under the limitation imposed by paragraph (1) as in effect without regard to this paragraph.

"(d) No payment may be made to a State under this part in excess of the payment made under this part for fiscal year 1979, for any fiscal year beginning after September 30, 1979, if for the latter fiscal year the total of the State's expenditures for child welfare services under this part (excluding expenditures for activities specified in subsection

(c)(1) is less than the total of the State's expenditures under this part (excluding expenditures for such activities) for fiscal year 1979.

"REALLOTMENT

"SEC. 424. The amount of any allotment to a State under section 421 for any fiscal year which the State certifies to the Secretary will not be required for carrying out the State plan developed as provided in section 422 shall be available for reallotment from time to time, on such dates as the Secretary may fix, to other States which the Secretary determines (1) have need in carrying out their State plans so developed for sums in excess of those previously allotted to them under section 421 and (2) will be able to use such excess amounts during such fiscal year. Such reallotments shall be made on the basis of the State plans so developed, after taking into consideration the population under the age of twenty-one, and the per capita income of each such State as compared with the population under the age of twenty-one, and the per capita income of all such States with respect to which such a determination by the Secretary has been made. Any amount so reallotted to a State shall be deemed part of its allotment under section 421. 42 USC 624.

"DEFINITIONS

"SEC. 425. (a)(1) For purposes of this title, the term 'child welfare services' means public social services which are directed toward the accomplishment of the following purposes: (A) protecting and promoting the welfare of all children, including handicapped, homeless, dependent, or neglected children; (B) preventing or remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation, or delinquency of children; (C) preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family where the prevention of child removal is desirable and possible; (D) restoring to their families children who have been removed, by the provision of services to the child and the families; (E) placing children in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate; and (F) assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption. 42 USC 625.

"(2) Funds expended by a State for any calendar quarter to comply with the statistical report required by section 476(b), and funds expended with respect to nonrecurring costs of adoption proceedings in the case of children placed for adoption with respect to whom assistance is provided under a State plan for adoption assistance approved under part E of this title, shall be deemed to have been expended for child welfare services. *Ante*, p. 501.

"(b) For other definitions relating to this part and to part E of this title, see section 475 of this Act.". *Ante*, p. 510.

(b) Part B of title IV of such Act is amended by adding at the end thereof the following new sections:

"FOSTER CARE PROTECTION REQUIRED FOR ADDITIONAL FEDERAL PAYMENTS

"SEC. 427. (a) If, for any fiscal year after fiscal year 1979, there is appropriated under section 420 a sum in excess of $141,000,000, a State shall not be eligible for payment from its allotment in an 42 USC 627.

amount greater than the amount for which it would be eligible if such appropriation were equal to $141,000,000, unless such State—

"(1) has conducted an inventory of all children who have been in foster care under the responsibility of the State for a period of six months preceding the inventory, and determined the appropriateness of, and necessity for, the current foster placement, whether the child can be or should be returned to his parents or should be freed for adoption, and the services necessary to facilitate either the return of the child or the placement of the child for adoption or legal guardianship; and

"(2) has implemented and is operating to the satisfaction of the Secretary—

"(A) a statewide information system from which the status, demographic characteristics, location, and goals for the placement of every child in foster care or who has been in such care within the preceding twelve months can readily be determined;

"(B) a case review system (as defined in section 475(5)) for each child receiving foster care under the supervision of the State; and

"(C) a service program designed to help children, where appropriate, return to families from which they have been removed or be placed for adoption or legal guardianship.

"(b) If, for each of any two consecutive fiscal years after the fiscal year 1979, there is appropriated under section 420 a sum equal to $266,000,000, each State's allotment amount for any fiscal year after such two consecutive fiscal years shall be reduced to an amount equal to its allotment amount for the fiscal year 1979, unless such State—

"(1) has completed an inventory of the type specified in subsection (a)(1);

"(2) has implemented and is operating the program and systems specified in subsection (a)(2); and

"(3) has implemented a preplacement preventive service program designed to help children remain with their families.

"(c) Any amounts expended by a State for the purpose of complying with the requirements of subsection (a) or (b) shall be conclusively presumed to have been expended for child welfare services.

"PAYMENTS TO INDIAN TRIBAL ORGANIZATIONS

42 USC 628

"SEC. 428. (a) The Secretary may, in appropriate cases (as determined by the Secretary) make payments under this part directly to an Indian tribal organization within any State which has a plan for child welfare services approved under this part. Such payments shall be made in such manner and in such amounts as the Secretary determines to be appropriate.

"(b) Amounts paid under subsection (a) shall be deemed to be a part of the allotment (as determined under section 421) for the State in which such Indian tribal organization is located.

"(c) For purposes of this section—

"Tribal organization."

"(1) the term 'tribal organization' means the recognized governing body of any Indian tribe, or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body; and

"Indian tribe"

"(2) the term 'Indian tribe' means any tribe, band, nation, or other organized group or community of Indians (including any Alaska Native village or regional or village corporation as

defined in or established pursuant to the Alaska Native Claims Settlement Act (Public Law 92-203; 85 Stat. 688)) which (A) is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians, or (B) is located on, or in proximity to, a Federal or State reservation or rancheria.". 43 USC 1601 note.

(c) In the case of Guam, Puerto Rico, and the Virgin Islands, and the Commonwealth of the Northern Mariana Islands, section 422(b)(1) of such Act (as otherwise amended by subsection (a) of this section) shall be deemed to read as follows: 42 USC 622 note. *Ante*, p. 517.

"(1) provide that (A) the State agency designated pursuant to section 402(a)(3) to administer or supervise the administration of the plan of the State approved under part A of this title will administer or supervise the administration of such plan for child welfare services, and (B) to the extent that child welfare services are furnished by the staff of the State agency or local agency administering such plan for child welfare services, the organizational unit in such State or local agency established pursuant to section 402(a)(15) will be responsible for furnishing such child welfare services;". 42 USC 602. 42 USC 601.

(d) Notwithstanding section 422(b)(1) of the Social Security Act (as amended by subsection (a) of this section) if on December 1, 1974, the agency of a State administering its plan for child welfare services under part B of title IV of that Act was not the agency designated pursuant to section 402(a)(3) of that Act, such section 422(b)(1) shall not apply with respect to such agency, but only so long as such agency is not the agency designated under section 2003(d)(1)(C) of that Act; and if on December 1, 1974, the local agency administering the plan of a State under part B of title IV of that Act in a subdivision of the State was not the local agency in such subdivision administering the plan of such State under part A of that title, such section 422(b)(1) shall not apply with respect to such local agency, but only so long as such local agency is not the local agency administering the program of the State for the provision of services under title XX of that Act. 42 USC 622 note. *Ante*, p. 517. *Ante*, p. 516. 42 USC 602. 42 USC 1397b. 42 USC 1397.

(e) Section 2002(a)(8) of such Act is amended by striking out "or 422" and inserting in lieu thereof "or 423". 42 USC 1397a. *Ante*, pp. 517, 518.

(f)(1) Notwithstanding any other provision of law, funds which are appropriated for fiscal year 1980 pursuant to section 420 of the Social Security Act, and for which States are eligible for payment under part B of title IV of that Act, shall remain available, to the extent so provided in an appropriation Act hereafter enacted, for payment with respect to expenditures for child welfare services under part B of title IV of that Act until September 30, 1981. 42 USC 620 note. *Ante*, p. 516.

(2) Section 420(b) of the Social Security Act (as added by subsection (a) of this section) shall apply only with respect to appropriation Acts, which appropriate funds for fiscal years after fiscal year 1981 pursuant to the authorization contained in section 420 of the Social Security Act, enacted after the date of enactment of this Act. Applicability.

TITLE II—SOCIAL SERVICES

DETERMINATION OF AMOUNT ALLOCATED TO STATES

SEC. 201. (a) Section 2002(a)(2)(A) of the Social Security Act is amended by striking out clause (ii) and inserting in lieu thereof the following: 42 USC 1397a.

"(ii) The amount specified for purposes of clause (i) for fiscal year 1980 and each succeeding fiscal year shall be an amount (not exceeding $3,300,000,000) equal to the indexed ceiling amount for that fiscal year as determined under subparagraph (B).".

42 USC 1397a.

(b) Section 2002(a)(2) of such Act is amended (subject to subsection (c) of this section) by striking out subparagraphs (B), (C), and (D), and by inserting after subparagraph (A) the following new subparagraph:

"(B)(i)(I) Except as otherwise provided in clauses (ii), (iii), and (iv), the indexed ceiling amount for any fiscal year shall be an amount equal to the indexed ceiling amount for the preceding fiscal year increased or decreased (as the case may be) by an amount determined under division (II).

"(II) For purposes of division (I) the amount of the increase or decrease (as the case may be) shall be an amount equal to $2,500,000,000, multiplied by a percentage equal to the positive or negative percentage change in the Consumer Price Index prepared by the Department of Labor, and used in determining cost-of-living adjustments under section 215(i) of this Act, for the second quarter of the preceding fiscal year as compared to such index for the second quarter of the second preceding fiscal year (rounded to the nearest one-tenth of 1 per centum). For purposes of this clause the Consumer Price Index for any quarter shall be the arithmetical mean of such index for the three months in such quarter.

42 USC 415.

"(ii) If the percentage increase in the Consumer Price Index as determined under clause (i)(II) for any fiscal year exceeds the inflation rate for that fiscal year as shown for that year (or, if no rate is shown for that year, for the most recent preceding year for which a rate is shown) in the table which appears on page 25 of Senate Budget Committee Report Numbered 96-311, then for such fiscal year such inflation rate shall be used in making the determination under clause (i)(II) instead of the percentage increase in the Consumer Price Index.

"(iii) The indexed ceiling amount determined under clause (i) shall, if not a multiple of $100,000,000, be rounded to the next lesser amount that is a multiple of $100,000,000.

"(iv) The indexed ceiling amount for fiscal year 1979 shall be $2,500,000,000."

(c) With respect to fiscal year 1980 only—

42 USC 1397a.

(1) subparagraphs (B) and (C) of section 2002(a)(2) of such Act (as in effect immediately prior to the enactment of this Act) shall continue in effect, redesignated as subparagraphs (D) and (E), respectively;

(2) the subparagraph of such section 2002(a)(2) which is redesignated as subparagraph (E) and continued in effect by paragraph (1) of this subsection is amended by striking out "subparagraph (B)" and "subparagraph (D)" and inserting in lieu thereof "subparagraph (D)" and "subparagraph (F)", respectively; and

(3) subparagraph (D) of such section 2002(a)(2) (as in effect immediately prior to the enactment of this Act) shall continue in effect, redesignated as subparagraph (F) and amended to read as follows:

"(F) The amounts made available pursuant to subparagraph (E) for allotment in fiscal year 1980 shall be allotted by the Secretary to the States which have certified under subparagraph (D) that the amounts of their limitations for such fiscal year are less than their need for such year. The amount of such allotment to any State (which shall be in addition to any payments made to the State under subparagraph (A)) shall bear the same ratio to

the total amount available for allotment in such year under this subparagraph as the population of such State bears to the population of the fifty States and the District of Columbia, but shall in no case exceed the amount by which such State certified that its limitation is less than its need for such fiscal year.".

EXTENSION OF 100-PER CENTUM FEDERAL MATCHING FOR CHILD DAY CARE EXPENDITURES

SEC. 202. (a) Section 2002(a) of the Social Security Act is amended by adding at the end thereof the following new paragraph: 42 USC 1397a.

"(17)(A) The total payment to a State under this section with respect to expenditures during any fiscal year for the provision of child day care services under this title (including expenditures for grants to qualified providers under section 2007) shall be equal to 100 per centum of such expenditures to the extent that such expenditures (during that fiscal year) do not exceed— 42 USC 1397f.

"(i) an amount which bears the same ratio to $200,000,000 as the amount of the State's limitation under paragraph (2)(A) bears to the indexed ceiling amount for such fiscal year, in the case of fiscal year 1980 and fiscal year 1981; or

"(ii) 8 per centum of the State's limitation under paragraph (2)(A) for such fiscal year, in the case of fiscal year 1982 and any subsequent fiscal year.

"(B) Federal funds payable to a State under this title (with respect to expenditures for child day care services) at the rate specified in subparagraph (A) shall, to the maximum extent that the State determines to be feasible, be employed in such a way as to increase the employment of welfare recipients and other low-income persons in jobs related to the provision of child day care services.".

(b) Section 2002(a)(1) of such Act is amended by striking out "100 per centum" and all that follows down through "2007" and inserting in lieu thereof "100 per centum of the expenditures during that quarter for child day care services (including expenditures for grants to qualified providers under section 2007) to the extent permitted by paragraph (17)".

LIMITATION ON FUNDS FOR TRAINING

SEC. 203. (a) The first sentence of section 2002(a)(2)(A)(i) of the Social Security Act is amended by striking out "in excess of an amount" and all that precedes it, and inserting in lieu thereof "Except as provided in clause (iii), no payment may be made under this section to any State for any fiscal year in excess of an amount". 42 USC 1397a.

(b) Section 2002(a)(2)(A) of such Act is further amended by adding after clause (ii) the following new clause:

"(iii) Payment with respect to expenditures for personnel training or retraining directly related to the provision of services under this title shall be made to a State in excess of the limitation for such State promulgated under clause (i) for any fiscal year and without regard to such limitation; except that—

"(I) notwithstanding any other provision of law, payment to a State with respect to such expenditures for fiscal years 1980 and 1981 may not exceed an amount equal to 4 per centum of such State's limitation (for the fiscal year involved) under clause (i), or, if greater, an amount equal to the amount of the payment made under this title to such State with respect to such expendi-

tures for fiscal year 1979, or equal to (a) the amount which would be payable without regard to this subclause with respect to expenditures pursuant to an appropriation made prior to October 1, 1979, by such State for fiscal year 1980, or, if less, (b) the amount determined under division (a) of this subclause reduced to the extent necessary and on a proportional basis so as to assure that the aggregate of the additional amounts payable to all States as a result of such division (a) does not exceed $6,000,000; and

Training plan, submittal to Secretary

"(II) payment to a State with respect to such expenditures for fiscal year 1982 or any succeeding fiscal year may be made only if the State has submitted to the Secretary in accordance with paragraph (18) (prior to the beginning of the fiscal year involved) a training plan specifying how its funds expended for such training or retraining in that fiscal year will be used, and only with respect to expenditures included in such plan which are approved by the Secretary in accordance with criteria prescribed by him.".

42 USC 1397a

(c) Section 2002(a) of such Act is amended by adding after paragraph (17) (as added by section 202(a) of this Act) the following new paragraph:

Ante, p. 523

"(18) Effective October 1, 1981, no payment may be made under this section for training or retraining expenditures except in accordance with a training plan approved by the Secretary which, at a minimum—

"(A) describes how training needs were assessed and how the assessment was used to structure the training programs, the individuals to be trained, and the training resources to be used;

42 USC 1397

"(B) demonstrates that the training activities have a direct relationship to the title XX services program and to the State's staffing needs to carry out the title XX services program; and

"(C) describes the State agency's plan to monitor training programs and to evaluate the agency's overall staff training and development program.".

USE OF RESTRICTED PRIVATE FUNDS FOR TRAINING PROGRAMS

42 USC 1397a

SEC. 204. (a) Section 2002(a)(7)(D)(ii) of the Social Security Act is amended by striking out "and" at the end thereof and inserting in lieu thereof the following: "except that during fiscal years 1980 and 1981 the provisions of this clause shall not apply with respect to funds that are donated for the purpose of training or retraining as provided in subsection (a)(1), if such training or retraining is carried out by a public or nonprofit entity, and".

EMERGENCY SHELTER

SEC. 205. (a) Section 2002(a)(11) of the Social Security Act is amended—

(1) by striking out "and" at the end of subparagraph (C);

(2) by striking out the period at the end of subparagraph (D) and inserting in lieu thereof "; and"; and

(3) by adding at the end thereof the following new subparagraph:

"(E) any expenditure for the provision of emergency shelter, for not in excess of thirty days in any six-month period, provided as a

protective service to an adult in danger of physical or mental injury, neglect, maltreatment, or exploitation.".

(b) The amendments made by this section shall be effective on and after October 1, 1979. Effective date. 42 USC 1397a note.

MULTIYEAR PLAN; CHOICE OF FISCAL YEAR

SEC. 206. (a) Section 2004(1) of the Social Security Act is amended to read as follows: 42 USC 1397c.

"(1) for each services program period, the beginning of the fiscal year of the Federal Government, the State government, or the political subdivisions of such State is established as the beginning of the State's services program period, and the end of such fiscal year, the succeeding fiscal year, or the second succeeding fiscal year is established as the end of the State's services program period; and".

(b) Section 2004 of such Act is further amended—

(1) by striking out "services program year" each place it appears and inserting in lieu thereof in each instance "services program period";

(2) by striking out "annual" in paragraph (2) (in the matter preceding subparagraph (A)) and in paragraph (4);

(3) by striking out "during that year" in paragraph (2) (in the matter preceding subparagraph (A)) and inserting in lieu thereof "during that period";

(4) by striking out the period at the end of paragraph (5) and inserting in lieu thereof "; and"; and

(5) by adding at the end thereof the following new paragraph:

"(6) in the case of a State that adopts a services program planning period of longer than one year, the State agency publishes and makes generally available such information concerning the comprehensive services program at such times as the Secretary may by regulation require.".

(c) Section 2003(b) of such Act is amended— 42 USC 1397b.

(1) by striking out "each services program year" and inserting in lieu thereof "each fiscal year (as selected by the State under section 2004(1)) within each services program period"; and

(2) by striking out "any services program year" and inserting in lieu thereof "any services program period".

(d) Sections 2003(d)(1) and 2005 of such Act are each amended by striking out "services program year" and inserting in lieu thereof "services program period". 42 USC 1397b, 1397d.

(e) Section 2002(a)(3)(B) of such Act is amended by striking out "annual". 42 USC 1397a.

(f) The amendments made by this section shall be effective with respect to services program periods beginning after the date of the enactment of this Act. Effective date. 42 USC 1397a note.

SOCIAL SERVICES FUNDING FOR TERRITORIES

SEC. 207. (a) Section 2002(a)(2) of the Social Security Act is amended by adding after subparagraph (B) (as added by section 201(b) of this Act) the following new subparagraph: 42 USC 1397a. *Ante*, p. 521.

"(C) From the amounts made available under section 2001 for any fiscal year beginning with fiscal year 1980 (in addition to any sums appropriated for purposes of payments under the preceding provisions of this subsection), the Secretary shall allocate—

"(i) to the jurisdictions of Puerto Rico, Guam, and the Virgin Islands, for purposes of payments under sections 3(a) (4) and (5), 403(a)(3), 1003(a) (3) and (4), 1403(a) (3) and (4), and 1603(a) (4) and (5), with respect to services, the sums of $15,000,000, $500,000 and $500,000, respectively, and

42 USC 603, 603, 1203, 1353, 1383 note

"(ii) to the jurisdiction of the Northern Mariana Islands, for purposes of payments under section 403(a)(3), with respect to services and for services programs for other individuals as defined by the Secretary, the sum of $100,000,

42 USC 603

in addition to any amounts otherwise available to such jurisdictions under this Act.".

42 USC 1397

(b) The last sentence of section 2001 of such Act is amended by inserting before the period at the end thereof the following: "(and to territorial jurisdictions as described in subsection (a)(2)(C) thereof)".

42 USC 1308, *post*, pp. 529, 550. *Ante*, p. 525

(c) Section 1108(a) of such Act is amended by striking out "section 2002(a)(2)(D)" and inserting in lieu thereof "section 2002(a)(2)(C)".

PERMANENT EXTENSION OF PROVISIONS RELATING TO CHILD DAY CARE SERVICES AND WIN TAX CREDIT

42 USC 1397e-1 note

SEC. 208. (a) Section 4(d) of Public Law 96-178 is amended by striking out "during the period beginning October 1, 1979, and ending March 31, 1980" and inserting in lieu thereof "on or after October 1, 1979".

93 Stat. 1295 26 USC 50B.

(b)(1) Section 50B(i) of the Internal Revenue Code of 1954 (relating to special rules with respect to employment of day care workers) is amended to read as follows:

"(i) SPECIAL RULES WITH RESPECT TO EMPLOYMENT OF DAY CARE WORKERS.—

"(1) ELIGIBLE EMPLOYEE.—An individual who would be an 'eligible employee' (as that term is defined for purposes of this section) except for the fact that such individual's employment is not on a substantially full-time basis, shall be deemed to be an eligible employee as so defined, if such employee's employment is related to the provision of child day care services and is performed on either a full-time or part-time basis.

"(2) ALTERNATIVE COMPUTATION WITH RESPECT TO CHILD DAY CARE SERVICES ELIGIBLE EMPLOYEES PAID FROM FUNDS MADE AVAILABLE UNDER TITLE XX OF THE SOCIAL SECURITY ACT.—The amount of the credit allowed a taxpayer under section 40, as determined under section 50A and the preceding provisions of this section, with respect to work incentive program expenses paid or incurred by him with respect to an eligible employee whose services are performed in connection with a child day care services program conducted by the taxpayer, and with respect to whom the taxpayer is reimbursed (in whole or in part) from funds made available pursuant to section 2007 of the Social Security Act, at the option of the taxpayer shall be equal to 100 percent of the unreimbursed wages paid or incurred by the taxpayer with respect to such employee, but not more than the amount of the limitation in paragraph (4).

42 USC 1397 26 USC 40 26 USC 50A.

42 USC 1397f

"(3) UNREIMBURSED WAGES.—For purposes of this subsection, the term 'unreimbursed wages' means work incentive program expenses for which the taxpayer was not reimbursed under section 2007 of the Social Security Act or under any other grant or program.

"(4) LIMITATION.—The amount of the credit, as determined under paragraph (2), with respect to any employee shall not exceed the lesser of—

"(A) an amount equal to $6,000 minus the amount of the funds reimbursed to the taxpayer with respect to such employee from funds made available pursuant to section 2007 of the Social Security Act; or 42 USC 1397f.

"(B) with respect to work incentive program expenses attributable to service rendered—

"(i) during the one-year period which begins on the day such employee begins work for the taxpayer, an amount equal to the lesser of—

"(I) $3,000, or

"(II) 50 percent of the sum of the amount of the unreimbursed wages of such employee and the amount reimbursed to the taxpayer with respect to such employee from funds made available pursuant to section 2007 of the Social Security Act; or

"(ii) during the one-year period which begins on the day after the last day of the one-year period described in clause (i), an amount equal to the lesser of—

"(I) $1,500, or

"(II) 25 percent of the sum of the amount of the unreimbursed wages of such employee and the amount reimbursed to the taxpayer with respect to such employee from funds made available pursuant to section 2007 of the Social Security Act.".

(2) Section 50B(h)(1)(B) of such Code is amended by inserting "(except as provided in subsection (i))" after "full-time basis". 26 USC 50B.

(3)(A) The amendments made by paragraphs (1) and (2) shall be effective with respect to taxable years beginning after December 31, 1979. Effective date. 26 USC 50B note.

(B) The redesignation of subsection (i) of section 50B of the Internal Revenue Code of 1954 as subsection (j) by section 3(a)(1) of Public Law 96-178, shall remain in effect with respect to taxable years beginning after December 31, 1979. 26 USC 50B note. 93 Stat. 1295.

PERMANENT EXTENSION OF PROVISIONS RELATING TO SERVICES FOR ALCOHOLICS AND DRUG ADDICTS

SEC. 209. Section 5(b) of Public Law 96-178 is amended by striking out "during the period beginning October 1, 1978, and ending March 31, 1980" and inserting in lieu thereof "on or after October 1, 1978". 93 Stat. 1297. 42 USC 1397a note.

TITLE III—OTHER SOCIAL SECURITY ACT PROVISIONS

PERMANENT EXTENSION OF PROVISIONS RELATING TO CHILD SUPPORT ENFORCEMENT

SEC. 301. (a) Section 2(b) of Public Law 96-178 is amended by striking out "during the period beginning October 1, 1978, and ending March 31, 1980" and inserting in lieu thereof "on or after October 1, 1978". 93 Stat. 1295. 42 USC 655 note.

(b) Section 452(a)(10) of the Social Security Act is amended by adding at the end thereof (after and below subparagraph (H)) the following new sentence: 42 USC 652.

"The information contained in any such report under subparagraph (A) shall specifically include (i) the total amount of child support payments collected as a result of services furnished during the fiscal year involved to individuals under section 454(6), (ii) the cost to the States and to the Federal Government of furnishing such services to those individuals, and (iii) the extent to which the furnishing of such services was successful in providing sufficient support to those individuals to assure that they did not require assistance under the State plan approved under part A.".

42 USC 654

42 USC 601

INCENTIVES TO REPORT EARNINGS UNDER AFDC PROGRAMS

42 USC 602

SEC. 302. (a) Section 402(a)(8) of the Social Security Act is amended—

(1) by inserting "or" at the end of subparagraph (D) thereof; and

(2) by adding after subparagraph (D) the following new subparagraph:

"(E) any of the persons specified in clause (ii) of subparagraph (A) with respect to which there is a failure without good cause to make a timely report (as prescribed by the State plan) to the State agency;".

Effective date
42 USC 602 note.

(b) The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

PRORATING OF SHELTER ALLOWANCE

SEC. 303. Part A of title IV of the Social Security Act is amended by adding at the end thereof the following new section:

"PRORATING OF SHELTER ALLOWANCE IN CERTAIN CASES WHERE CHILD LIVES WITH RELATIVE NOT LEGALLY RESPONSIBLE FOR HIS SUPPORT

42 USC 612

"SEC. 412. (a) Notwithstanding any other provision of this part, a State plan for aid and services to needy families with children shall not be regarded as failing to comply with the requirements imposed under this part solely because, under such plan, in any case in which one or more children live in any household—

"(1)(A) in which the total income of such child or children and the closely related family members (as defined in subsection (b)) living in the same household equals or exceeds the standard of need under such plan for a family equal in number to the total number of such children and closely related family members in the same household, or (B) where the income of children and family members cannot be determined due to failure to cooperate, and

"(2) which (A) does not include a relative (specified in section 406(a)(1)) who is legally responsible for the support of the child or children, or (B) includes one or more such relatives who is legally responsible for the support of the child or children but none of whom is eligible for aid under the State plan because such relative is being supported by another person or under another program,

42 USC 606

the amount of the aid furnished with respect to such child or children for shelter, utilities, and similar expenses, bears the same ratio to the total amount which would be furnished for such expenses, if all the closely related family members with whom such child or children are

living were eligible for such aid, as the number of such children bears to the total number of such children and closely related family members.

"(b) For purposes of subsection (a), the term 'closely related family members' of a child means those relatives of his who are specified in section 406(a)(1) and any other individual for whose support such a relative is legally responsible, but does not include any such relative or other individual (1) with respect to whom benefits are provided under another public program eligibility for which is based on need, or (2) whose presence in the home would not increase the total amount which would be allowed for shelter, utilities, and similar expenses if he was eligible for aid.

"Closely related family members." 42 USC 606.

"(c) The amount of aid to families with dependent children for shelter, utilities, and similar expenses shall be identified, for purposes of this section, in the following manner:

"(1) If the State plan approved under this part provides for paying 100 per centum of the standard of need specified in the plan, and designates a portion of that standard, for families of specified sizes, to meet shelter, utilities, and similar expenses, then an amount equal to that portion shall be considered the total amount for such expenses for a family of the specified size.

"(2) If such plan provides for meeting less than 100 per centum of such standard, and designates a portion of that standard, for families of specified sizes, to meet such expenses, then an amount equal to that portion, multiplied by the proportion of the standard of need which such State pays as aid to families with dependent children, shall be considered the total amount for such expenses for a family of the specified size.

"(3) If such plan does not designate any portion of the standard of need for meeting such expenses, then such portion shall be prescribed by the Secretary, but in no event shall such portion exceed 30 per centum of the standard of need for a family of a specified size, multiplied by the proportion of such standard which the State pays as aid to families with dependent children.

"(d) For purposes of subsection (a), the total income of the child or children and the closely related family members (as defined in subsection (b)) shall be determined as it would be if all such individuals were applicants for aid under the State plan and shall not include any income which any such individual is obligated to apply to the support of any other individual not living in the household.".

SERVICES FOR DISABLED CHILDREN

SEC. 304. Section 1615 of the Social Security Act is amended by redesignating the second subsection (c) as subsection (e), and by striking out "October 1, 1979" in paragraph (1) of such subsection (e) and inserting in lieu thereof "October 1, 1982". 42 USC 1382d.

PUBLIC ASSISTANCE PAYMENTS TO TERRITORIAL JURISDICTIONS

SEC. 305. (a) Section 1108(a) of the Social Security Act is amended— *Ante*, p. 526. *Post*, p. 530.

(1) by striking out "with respect to the fiscal year 1972 and each fiscal year thereafter other than the fiscal year 1979" in paragraphs (1)(E), (2)(E), and (3)(E) and inserting in lieu thereof in each instance "with respect to each of the fiscal years 1972 through 1978"; and

(2) by striking out "with respect to the fiscal year 1979" in paragraphs (1)(F), (2)(F), and (3)(F) and inserting in lieu thereof in each instance "with respect to the fiscal year 1979 and each fiscal year thereafter".

Ante, pp. 526, 529.

(b) Section 1108(a) of such Act is further amended by striking out "under part A" in the matter preceding paragraph (1) and inserting in lieu thereof "under parts A and E".

42 USC 601, *ante*, p. 501.

(c) The last sentence of section 1118 of such Act is amended by striking out "when applied to quarters in the fiscal year ending September 30, 1979".

42 USC 1318.

PERIOD WITHIN WHICH CERTAIN CLAIMS MUST BE FILED

SEC. 306. (a) Part A of title XI of the Social Security Act is amended by adding after section 1131 the following new section:

"PERIOD WITHIN WHICH CERTAIN CLAIMS MUST BE FILED

42 USC 1320b-2.

"SEC. 1132. (a) Notwithstanding any other provision of this Act (but subject to subsection (b)), any claim by a State for payment with respect to an expenditure made during any calendar quarter by the State—

"(1) in carrying out a State plan approved under title I, IV, V, X, XIV, XVI, XIX, or XX of this Act, or

42 USC 301, 601, 701, 1201, 1351, 1381, 1396, 1397.

"(2) under any other provision of this Act which provides (on an entitlement basis) for Federal financial participation in expenditures made under State plans or programs,

shall be filed (in such form and manner as the Secretary shall by regulations prescribe) within the two-year period which begins on the first day of the calendar quarter immediately following such calendar quarter; and payment shall not be made under this Act on account of any such expenditure if claim therefor is not made within such two-year period; except that this subsection shall not be applied so as to deny payment with respect to any expenditure involving court-ordered retroactive payments or audit exceptions, or adjustments to prior year costs.

"(b) The Secretary shall waive the requirement imposed under subsection (a) with respect to the filing of any claim if he determines (in accordance with regulations) that there was good cause for the failure by the State to file such claim within the period prescribed under subsection (a). Any such waiver shall be only for such additional period of time as may be necessary to provide the State with a reasonable opportunity to file such claim. A failure to file a claim within such time period which is attributable to neglect or administrative inadequacies shall be deemed not to be for good cause.".

Effective date. 42 USC 1320b-2 note.

(b)(1) The amendment made by subsection (a) shall be effective only in the case of claims filed on account of expenditures made in calendar quarters commencing on or after October 1, 1979.

(2) In the case of claims filed prior to the date of enactment of this Act on account of expenditures described in section 1132 of the Social Security Act made in calendar quarters commencing prior to October 1, 1979, there shall be no time limit for the payment of such claims.

(3) In the case of such expenditures made in calendar quarters commencing prior to October 1, 1979, for which no claim has been filed on or before the date of enactment of this Act, payment shall not be made under this Act on account of any such expenditure unless

claim therefor is filed (in such form and manner as the Secretary shall by regulation prescribe) prior to January 1, 1981.

(4) The provisions of this subsection shall not be applied so as to deny payment with respect to any expenditure involving adjustments to prior year costs or court-ordered retroactive payments or audit exceptions. The Secretary may waive the requirements of paragraph (3) in the same manner as under section 1132(b) of the Social Security Act.

(c) Notwithstanding any other provision of law, there shall be no time limit for the filing or payment of such claims except as provided in this section, unless such other provision of law, in imposing such a time limitation, specifically exempts such filing or payment from the provisions of this section. 42 USC 1320b-2 note.

INCENTIVES FOR STATES TO COLLECT CHILD SUPPORT OBLIGATIONS

SEC. 307. (a) The heading of section 458 of the Social Security Act is amended by inserting "STATES AND" after "TO". 42 USC 658.

(b) Section 458(a) of such Act is amended—

(1) by inserting "or a State on its own behalf makes," after "another State,", and

(2) by striking out "or such other State" and inserting in lieu thereof ", such other State, or such State (in the case of a State which on its own behalf makes such enforcement and collection)".

(c) Section 458 of such Act is further amended by adding at the end thereof the following new subsection:

"(c) No payment under the preceding provisions of this section shall be made to any State or political subdivision thereof with respect to any amount collected and distributed by it unless such amount was collected and distributed in accordance with the State plan of the State approved by the Secretary as meeting the conditions required by section 454.". 42 USC 654.

EXCHANGE OF INFORMATION ON TERMINATED OR SUSPENDED PROVIDERS

SEC. 308. (a) Section 1862(d) of the Social Security Act is amended by adding at the end thereof the following new paragraph: 42 USC 1395y.

"(4) The Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of any determination made under the provisions of this subsection.". 42 USC 1396.

(b) Section 1866(c) of such Act is amended by adding at the end thereof the following new paragraph: 42 USC 1395cc.

"(3) Where an agreement filed under this title by a provider of services has been terminated by the Secretary, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of such termination.".

(c) Section 1902(a) of such Act is amended— 42 USC 1396a.

(1) by striking out "and" at the end of paragraph (39);

(2) by striking out the period at the end of paragraph (40) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (40) the following new paragraph:

"(41) provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary of such action.".

POSTPONEMENT OF IMPOSITION OF CERTAIN PENALTIES RELATING TO CHILD SUPPORT REQUIREMENTS

42 USC 603 note. 42 USC 601. 42 USC 603.

SEC. 309. No reduction in the amount payable to any State under title IV of the Social Security Act with respect to fiscal year 1977 or fiscal year 1978 shall be made prior to October 1, 1980, on account of the provisions of section 403(h) of such Act.

CONTINUING MEDICAID ELIGIBILITY FOR CERTAIN RECIPIENTS OF VETERANS' ADMINISTRATION PENSIONS

SEC. 310. (a)(1) Part A of title XI of the Social Security Act is amended by adding after section 1132 (as added by section 305 of this Act) the following new section:

Ante, p. 530.

"APPLICANTS OR RECIPIENTS UNDER PUBLIC ASSISTANCE PROGRAMS NOT TO BE REQUIRED TO MAKE ELECTION RESPECTING CERTAIN VETERANS' BENEFITS

42 USC 1320b-3.

"SEC. 1133. (a) Notwithstanding any other provision of law (but subject to subsection (b)), no individual who is an applicant for or recipient of aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV, or of benefits under the Supplemental Security Income program established by title XVI shall—

42 USC 301, 1201, 1351, 1381, 601.

"(1) be required, as a condition of eligibility for (or of continuing to receive) such aid, assistance, or benefits, to make an election under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 with respect to pension paid by the Veterans' Administration, or

38 USC 521 note.

"(2) by reason of failure or refusal to make such an election, be denied (or suffer a reduction in the amount of) such aid, assistance, or benefits.

"(b) The provisions of subsection (a) shall be applicable only with respect to an individual, who is an applicant for or recipient of aid, assistance, or benefits described in subsection (a), during a period with respect to which there is in effect—

"(1) in case such individual is an applicant for or recipient of aid or assistance under a State plan referred to in subsection (a), in the State having such plan, or

"(2) in case such individual is an applicant for or recipient of benefits under the Supplemental Security Income program established by title XVI, in the State in which the individual applies for or receives such benefits,

42 USC 1381.

42 USC 1396.

a State plan for medical assistance, approved under title XIX, under which medical assistance is available to such individual only for periods for which such individual is a recipient of aid, assistance, or benefits described in subsection (a).".

Effective date. 42 USC 1320 b-3 note.

(2) The amendment made by paragraph (1) shall be effective on and after January 1, 1979; except that nothing contained in such amendment shall be construed to authorize or require any payment (or increase in payment) of any aid or assistance or benefits referred to in section 1133(a) of the Social Security Act (as added by paragraph (1))

for any benefit period which begins prior to the date of enactment of this Act.

(b)(1)(A) For purposes of section 1902(a)(10)(A) of the Social Security Act, any individual who, prior to the date of enactment of this Act and for the month of December 1978, was eligible for and received aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of such Act, or was eligible for and received supplemental security income benefits under title XVI of such Act (or a supplementary payment described in section 13(c) of Public Law 93-233), and was also in receipt of (or was a dependent, for purposes of chapter 15 of title 38, United States Code, as in effect on December 31, 1978, of an individual in receipt of) pension from the Veterans' Administration for the month of December 1978 shall (subject to subparagraph (B)) be deemed to have been receiving such aid, assistance, supplemental security income, or supplementary payment, for each calendar month thereafter (prior to the month in which the provisions of this subparagraph cease to be effective with respect to him as determined under subparagraph (B)), if such individual would have been eligible therefor in December 1978 and in the month in which the provisions of this subparagraph cease to be effective with respect to him as determined under subparagraph (B) had the increase in income of such individual (or of the family of which such individual is a member), attributable to an election (made by such individual or another member of such individual's family) under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978, not occurred.

42 USC 1396a note.
42 USC 1396a.
42 USC 301, 1201, 1351, 1381, 601.
42 USC 1396a note.
38 USC 501 *et seq.*
38 USC 521 note.

(B)(i) The provisions of subparagraph (A) shall take effect on January 1, 1979, and shall cease to be effective, in the case of any individual, for and after the first calendar month beginning more than 10 days after an "informed election" (as defined in subdivision (ii) of this subparagraph) has been made by such individual (or, if such individual is not eligible to make such an election, by a member of such individual's family who is eligible to make such an election which affects such individual's eligibility for aid, assistance, or benefits under a plan or program referred to in subparagraph (A)).

Effective date.

(ii) The term "informed election" means an election made under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 (or a reaffirmation of such an election which previously was made under such section 306) after the date of compliance by the Administrator of Veterans' Affairs (hereinafter in this section referred to as the "Administrator") with the provisions of paragraph (2)(A) with respect to the individual concerned. An individual who fails, within the time limits prescribed in paragraph (2)(B), to disaffirm an election previously made by such individual under such section 306 shall be deemed, for purposes of this section and such section 306, to have reaffirmed such election.

"Informed election."
38 USC 521 note.

(2)(A) The Administrator shall provide to each individual to whom section 1133 of the Social Security Act (as added by subsection (a)(1) of this section) applies and who is eligible to make or has made an election under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978, a written notice, in clear and understandable language, which (i) describes the consequences to such individual (and possibly to such individual's family), in terms of a determination or possible determination of ineligibility for medical assistance under a State plan approved under title XIX of the Social Security Act, of making an election with respect to pension under such section 306, (ii) describes the provisions of subparagraph (B) of this paragraph and

42 USC 1320b-3 note.
Ante, p. 532.
38 USC 521 note.
42 USC 1396.

subsection (a) of this section, (iii) sets forth other relevant information that would be helpful to such individual in making an informed decision concerning such an election or the disaffirmation thereof, and (iv) in the case of any individual who has made such an election, is accompanied by a form prepared for the purpose of enabling such individual to file with the Administrator a written disaffirmation of such an election.

(B) Notwithstanding any other provision of law—

Ante, p. 532

(i) any individual to whom section 1133 of the Social Security Act (as added by subsection (a)(1) of this section) applies may, within the 90-day period beginning with the day that there is mailed to such individual (at such individual's last known mailing address) a notice referred to in subparagraph (A), disaffirm an election previously made by such individual under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 by completing and mailing to the Administrator the form furnished such individual for such purpose by the Administrator pursuant to subparagraph (A),

38 USC 521 note

(ii) whenever any such individual files such a disaffirmation with the Administrator, the amount of pension payable to such individual shall be adjusted, beginning with the first calendar month which commences after the receipt by the Administrator of such disaffirmation, to the amount that such pension would have been if such an election by such individual had not been made,

(iii) any individual who has filed a disaffirmation, pursuant to this subparagraph, of an election made by such individual under such section 306 may again make an election thereunder, but such subsequent election may not be disaffirmed under this subsection, and

(iv) no indebtedness to the United States, as a result of the disaffirmation by an individual, pursuant to this subparagraph, of an election made by such individual under such section 306 shall be considered to arise from the payment of pension pursuant to such an election.

(C) The Administrator shall promptly advise the Secretary of Health, Education, and Welfare, and provide identification of the individuals involved and other pertinent information with respect to (i) disaffirmations of elections made by individuals pursuant to subparagraph (B), (ii) individuals who, by failing to disaffirm within the 90-day period prescribed in subparagraph (B), are deemed to have reaffirmed elections previously made, and (iii) individuals who, after having disaffirmed an election under subparagraph (B), subsequently again make an election under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978. The Secretary, upon receipt of any such information with respect to an individual, shall promptly notify the appropriate agencies administering State plans approved under title I, X, XIV, XIX, and part A of title IV of the Social Security Act, and State agencies making supplemental payments pursuant to section 1616 of such Act or an agreement entered into pursuant to section 212(a) of Public Law 93-66.

38 USC 521 note.

42 USC 301, 1201, 1351, 1396, 601. 42 USC 1382e. 87 Stat. 155.

Approved June 17, 1980.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 96-136 (Comm. on Ways and Means), No. 96-136, Pt. 2 (Comm. on Appropriations), and No. 96-900 (Comm. of Conference).
SENATE REPORT No. 96-336 (Comm. on Finance).
CONGRESSIONAL RECORD:
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Oct. 25, 29, considered and passed Senate, amended.
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WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS:
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96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 96-136

SOCIAL SERVICES AND CHILD WELFARE AMENDMENTS OF 1979

MAY 10, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed.

Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 3434]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3434) to amend the Social Security Act to make needed improvements in the child welfare and social services programs, to strengthen and improve the program of Federal support for foster care of needy and dependent children, to establish a program of Federal support to encourage adoptions of children with special needs, and for other purposes, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 2, strike out the matter in the table of contents relating to titles II and III and insert in lieu theeof the following:

TITLE II—CHILD WELFARE SERVICES

Sec. 201. Amendments to child welfare services program.

TITLE III—FOSTER CARE AND ADOPTION ASSISTANCE

Sec. 301. Federal payments for dependent children voluntarily placed in foster care.
Sec. 302. Adoption assistance payments under aid to families with dependent children foster care program.

TITLE IV—MISCELLANEOUS

Sec. 401. Public assistance payments to territorial jurisdictions.
Sec. 402. Effective dates.

Page 14, lines 17 and 18, strike out ", FOSTER CARE, AND ADOPTION ASSISTANCE".

Page 22, line 21, insert "the second sentence of" before "subsection (b)".

Page 24, strike out "preventive" in line 11 and all that follows down through ", and" in line 15.

Page 27, line 10, insert quotation marks before (d)(1).

Page 27, line 22, insert "the second sentence of" before "subsection (b)".

Page 28, strike out "If" in line 4 and all that follows down through "inapplicable," in line 8 and insert in lieu thereof the following:

> If any State has not completed all of the actions described in the second sentence of subsection (b) and placed in effect all of the laws, regulations, standards, practices, and procedures described in paragraphs (2) through (8) of subsection (c) prior to the beginning of the fiscal year 1982, both this subsection and the first sentence of subsection (b) shall be inapplicable.

Page 28, line 11, after "until" insert "all of the actions described in the second sentence of subsection (b) have been completed and".

Page 32, strike out line 20 and all that follows down through page 33, line 12.

Page 33, line 13, strike out "(7)" and insert in lieu thereof "(5)".

Page 33, line 16, strike out "(8)" and insert in lieu thereof "(6)".

Page 33, line 22, strike out "(9)" and insert in lieu thereof "(7)".

Page 34, line 7, strike out "section 422(1)" and insert in lieu thereof "section 422(b)(1) (as otherwise amended by subsection (a) of this section)".

Page 34, line 20, strike out "section 422(a)(1)" and insert in lieu thereof "section 422(b)(1)".

Page 34, line 21, after "Act" insert "(as amended by subsection (a) of this section)".

Page 34, line 24, strike out "section 422(a)(1)" and insert in lieu thereof "section 422(b)(1)".

Page 35, line 6, strike out "section 422(a)(1)" and insert in lieu thereof "section 422(b)(1)".

Page 35, after line 21, insert the following:

TITLE III—FOSTER CARE AND ADOPTION ASSISTANCE

Page 35, line 24, strike out "Sec. 202." and insert in lieu thereof "Sec. 301.".

Page 39, line 3, strike out "February 1, 1979," and insert in lieu thereof "the date of the enactment of the Social Services and Child Welfare Amendments of 1979".

Page 41, strike out lines 1 through 3 and insert in lieu thereof the following:

> "(f) For purposes of this section—
>
> "(1) the term 'foster family home' means a foster family home for children which is licensed by the State in which it is situated, or which has been approved, by the agency of such State responsible for licensing homes of this type, as meeting the standards established for such licensing; and

"(2) the term 'child-care institution' means a public institution accommodating not more than twenty-five children, or a nonprofit private child-care institution, which is licensed by the State in which it is situated, or which is approved, by the agency of such State responsible for the licensing or approval of institutions of this type, as meeting the standards established for such licensing; but such term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily to accommodate children who are delinquent.

For definitions of other terms used in this section, see section 425(b).".

Page 43, line 6, strike out "Sec. 203." and insert in lieu thereof "Sec. 302.".

Page 47, line 13, strike out "III" and insert in lieu thereof "IV".

Page 47, line 16, strike out "Sec. 301." and insert in lieu thereof "Sec. 401.".

Page 48, line 7, strike out "Sec. 302." and insert in lieu thereof "Sec. 402.".

Page 48, line 8, strike out "301" and insert in lieu thereof "401".

Page 48, lines 11 and 12, strike out "section 105" and insert in lieu thereof "sections 105 and 197".

Page 48, lines 15 and 16, strike out "its next succeeding comprehensive services plan" and insert in lieu thereof "succeeding comprehensive services plans".

Page 48, line 17, strike out "title II" and insert in lieu thereof "titles II and III".

CONTENTS

I. Summary.
II. Comparison with present law.
III. Background and statistical information.
IV. Section-by-section explanation and justification.
V. Cost estimate.
VI. Other matters required to be discussed under the rules of the House.
VII. Changes in existing law made by the bill, as reported.

I. SUMMARY

I. Title XX Social Services

1. *Statutory Ceiling on Federal Funds.*—The ceiling would be increased to $3.1 billion beginning in fiscal 1980. (The ceiling is currently at $2.9 billion and drops to $2.5 billion September 30, 1979.)

2. *Special Allocation for Child Day Care Services.*—Of the total amount of funds available under the statutory ceiling, $200 million would be available in fiscal 1980 and 1981 for child care with no State matching requirement.

3. *Grants for Hiring Welfare Recipients as Child Care Workers.*—Effective October 1, 1979, States could use their share of the $200 million in child care funds for grants to employers who hire welfare recipients as child care workers.

4. *Title XX Training Funds.*—For fiscal 1980 only, Federal matching funds for training would be limited to an amount equal to 3 percent

of the State's fiscal 1980 allotment of funds under the statutory ceiling. States that received more Federal training funds in fiscal 1979 than 3 percent of their 1980 allotment could receive additional funds equal to two-thirds of the amount by which Federal training funds received in fiscal 1979 exceeded 3 percent of their 1980 allotment. Beginning in fiscal 1981, and for each year thereafter, States would be reimbursed only for those training expenditures that have been included in and approved by HEW as a part of a State title XX training plan.

5. *Consultation With Local Officials.*—Beginning in fiscal 1981, States would be required, prior to publication of their proposed title XX plan, to give public notice of intent to consult with local elected officials and provide them the opportunity to present their views. The principal views of the local officials would have to be included in the proposed title XX plan.

6. *Multiyear Planning.*—States would be given the option of using a 1, 2, or 3-year title XX program period. The Secretary of HEW would have authority to require States that opt for a multi-year program period to make information about their plan available at times during the program period.

7. *Plan Requirement for Distribution of Funds Within the State.*—States would be required to include in their title XX plans the criteria used to determine the nature and amount of services provided in each geographic area within the State.

8. *Services to Alcoholics and Drug Addicts.*—The current temporary authority relating to the use of title XX funds for certain services provided to alcoholics and drug addicts would be made permanent, effective October 1, 1979.

9. *Emergency Shelter.*—Effective October 1, 1979, title XX funds could be used for emergency shelter, for not in excess of 30 days in any 6 month period, provided as a protective service to an *adult* in danger of physical or mental injury, neglect, maltreatment or exploitation.

10. *Title XX Goals.*—Language would be added stating that it is the purpose of title XX to meet social services needs which are not otherwise being met, particularly in areas of the State with special needs, in order to make available a comprehensive range of services to eligible beneficiaries.

11. *Social Services Entitlement for Puerto Rico, Guam, the Virgin Islands and the Northern Marianas.*—Beginning in fiscal year 1980, a separate title XX entitlement would be established in the following amounts:

	Millions
Puerto Rico	$15.0
Guam	.5
Virgin Islands	.5
Northern Marianas	.1
Total	16.1

II. Title IV–B Child Welfare Services

12. *Federal IV–B Child Welfare Services Funds.*—$266 million per fiscal year would be available to States on an entitlement basis for IV–B child welfare services. (This would replace the present IV–B

authorization of $266 million for child welfare services which was funded at $56.5 million in fiscal year 1979.)

The definition of "child welfare services" would be changed to place emphasis on services directed toward preventing the removal of children from their homes, reuniting children with their families, placing children in suitable adoptive homes if restoration to the family is not possible, as well as generally protecting and promoting the welfare of all children.

13. *Two-Stage Allotment of New IV–B Funds.*—(*a*) *First allotment.*—Beginning in fiscal year 1980 (October 1, 1979), 40 percent of the new IV–B funds ($84 million) would be available to States to enable them to improve and expand their IV–B services and to complete case reviews on all children in foster care. In order to continue receiving its share of the first allotment beyond fiscal 1981, a State would have to have in place all the foster care safeguards, procedures and services, except the preplacement preventive services (section 424(c)(1)), required under section 424 of the Social Security Act as revised by this bill. (Summarized under item No. 16 below).

(*b*) *Second allotment.*—Beginning in fiscal 1981 (October 1, 1980), a State would be eligible for its share of the remaining 60 percent of the new IV–B funds ($125.5 million) after the State had (1) completed case reviews of all children who have been in foster care for over 6 months and submitted a report to the Secretary of HEW based on this review; (2) demonstrated that at least 40 percent of the amount of Federal IV–B funds received in excess of such funds received for fiscal 1979 would be spent for services aimed at keeping children with or returning them to their families; and (3) implemented the foster care safeguards, procedures, and services required under section 424. However, beginning in fiscal 1981, a State could receive its share of the second allotment when it met the first and second conditions listed above and had in place all the safeguards, procedures and services, except the preplacement preventive services (section 424(c)(1)), required under section 424. Such a State would have to have implemented the required preplacement preventive services by the end of the fiscal year following the fiscal year in which it began receiving its share of the second allotment in order to continue receiving second allotment funds.

14. *IV–B State Matching Requirement and Allocation Formula.*—There would be a 25 percent State matching requirement for IV–B funds.

IV–B funds would continue to be allocated according to the formula in present law. Each State would receive a uniform grant of $70,000 a year, plus an additional amount varying directly with the number of children under age 21 and inversely with average per capita income.

The provision in current law allowing reallocation of unused IV–B funds would be repealed.

If so appropriated, IV–B funds allocated to a State for fiscal 1980 would remain available for use by the State through fiscal 1981.

15. *Limitations on IV–B Expenditures and Maintenance of Effort Requirement.*—A State would not receive more Federal IV–B funds for adoption assistance payments, foster care maintenance payments, and employment-related child day care services than the State's total fiscal 1979 IV–B allotment.

A State could not spend less for child welfare services under IV–B and under title XX than the total amount of State expenditures for such services in fiscal 1979.

16. *Foster Care Protections, Procedures and Services.*—In accordance with the two-stage allotment procedure and other conditions summarized above, additional Federal IV–B child welfare services funds would be made available to the States for the purpose of assisting and encouraging them to implement the services, procedures and protections necessary to provide and insure: (1) that no child will be placed in foster care, except in emergency situations, either voluntarily or involuntarily, unless services aimed at preventing the need for placement have been provided or refused by the family; (2) that no child will be involuntarily removed from his or her home, except on a short-term basis in emergency situations, unless there has been a judicial determination that the child should be removed; (3) that no child will be placed in foster care by the voluntary action of his or her parents unless a "voluntary placement agreement" has been signed by parents and agency; (4) that a child who has been removed from his or her home will be placed in the least restrictive family-like setting in which any special needs may be met, within reasonable proximity to his or her family and with relatives where appropriate; (5) that reunification services are made available to the child and his or her parents after removal from the home; (6) that there will be a written individualized case plan developed for each child placed in foster care, an administrative review of each case plan at least every 6 months, and a dispositional hearing by a court or court-appointed administrative body within 18 months of the child's placement; and (7) that a fair hearing be provided for any parent, foster parent, guardian or child who believes he or she has been aggrieved by any governmental action taken under this section.

III. AFDC Foster Care and Adoption Assistance

17. *Federal Matching for Voluntarily Placed AFDC Foster Care Children.*—(*a*) After the Secretary of HEW has determined that a State has in place all the protections, procedures and services required under section 424 (summarized in item No. 16), Federal AFDC matching funds would be available for foster care payments for an AFDC-eligible child who has been removed from his or her home pursuant to a voluntary placement agreement.

(*b*) A child who was removed from his or her home prior to date of enactment of this bill without a judicial determination would become eligible for Federal matching funds for future foster care payments (1) after the State had implemented all the foster care protections, procedures and services, except for the preplacement preventive services (section 424(c)(1)), required under section 424, and (2) after a written individualized case plan had been prepared for the child and reviewed in accordance with the new section 408(e)(2) of the Social Security Act added by this bill.

18. *Federal Matching Funds for Foster Care in Certain Public Institutions.*—Federal matching funds would be available for foster care provided in publicly-operated child care institutions which care for 25 or fewer children.

19. *Federal Matching Funds for Adoption Assistance.*—States would be required to include an adoption assistance program as part of their AFDC program. Federal AFDC matching funds would be available for adoption assistance payments under the conditions and limitations described below.

Eligibility of the Child.—The assistance could be provided on behalf of an AFDC foster care-eligible child or an SSI-eligible child who has been determined by the State to have "special needs."

Special needs exist when the State has determined (1) that the child cannot or should not be returned to his or her own home; (2) that there is a specific condition (such as age; physical, mental, emotional, or medical handicap; or membership in a minority or sibling group) because of which it is reasonable to conclude the child cannot be placed without assistance; and (3), except where it would be contrary to the best interest of the child, efforts have been made to place the child without providing an adoption assistance payment.

Amount of the Assistance.—The amount of the adoption assistance payments, if any, would be determined by agreement between the adoptive parents and the administering agency, taking into consideration the economic circumstances of the adopting parents and the needs of the child. It would be subject to periodic adjustment upon a change in those circumstances. The amount of the payment could not exceed the amount which would have been paid had the child been in a foster family home in the State. However, it could initially include an amount to cover the non-recurring expenses associated with the adoption of the child.

Children for whom adoption assistance payments are made would be eligible for Medicaid on the same basis as AFDC and AFDC foster care children.

Duration of the Assistance.—Adoption assistance payments could continue until the child reaches age 18. In the case of a child with a physical or mental handicap, the State could continue assistance until age 21. It would cease before the child reached age 18 (or 21) if the State determined that the child was no longer receiving any support from the parents.

IV. Public Assistance Payments to Territorial Jurisdictions

20. *Federal Matching Funds for AFDC, OAA and APTD in Puerto Rico, Guam and the Virgin Islands.*—The current $78 million funding level and 75 matching percent rate, provided for fiscal 1979 under Public Law 95–600, would be made permanent.

		(1)), required under section 424. Such a state would have to have implemented the required preplacement preventive services by the end of the fiscal year following the fiscal year in which it began receiving its share of the second allotment in order to continue receiving second allotment funds.
14. IV–B State matching requirement and allocation formula. (Sec. 201.)	The Federal matching rate ranges from 33⅓ to 66⅔ percent. From the amount appropriated, each State receives a uniform grant of $70,000 a year, plus an additional amount which varies directly with the number of children under age 21 and inversely with average per capital income. (Sec. 421.)	There would be a 25 percent State matching requirement for IV–B funds. IV–B funds would continue to be allocated according to the formula in present law. The provision in current law allowing reallocation of unused IV–B funds would be repealed. If so appropriated, IV–B funds allocated to a State for fiscal 1980 would remain available for use by the State through fiscal 1981.
15. Maintenance of effort requirement. (Sec. 201.)	No requirement.	A State would not receive more Federal IV–B funds for adoption assistance payments, foster care maintenance payments, and employment-related child day care services than the State's total fiscal 1979 IV–B allotment. A State could not spend less for child welfare services under IV–B and under title XX than the total amount of State expenditures for such services in fiscal 1979.

2. Title IV–B Child Welfare Services

When the Social Security Act was passed in 1935, it included provisions for Federal funding for child welfare services "for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent." The original authorization was for $1.5 million, to be used by the States in carrying out their plans for services to children in predominantly rural areas and other areas of special need. The law has been amended many times in the succeeding years. Funding levels have been increased, the rules for allocation of funds to the States have been changed, and the purpose of the legislation has been broadened.

The most recent amendments to the child welfare services program were enacted in 1972. In the Social Security Amendments of 1972, the Congress authorized a major increase in the amount of Federal funding for such services. House and Senate committee reports on that legislation referred to the need for increased funds for foster care and for preventive child welfare services to enable children to remain with their families and avoid the need for foster care. The increased funds were also to be used by the States for adoption services, including activities to increase adoptions of hard-to-place children.

Although the amount of money authorized by the Congress in 1972 was established at steadily increasing levels, starting at $196 million for the fiscal year 1973 and increasing to $266 million for 1977 and years thereafter, the level of appropriations for child welfare services has remained low, never exceeding $56.5 million, or about 21 percent of the amount currently authorized. The burden of the cost of the child welfare program has fallen mostly on State and local governments. It is estimated that combined State and Federal expenditures reported under the title IV–B program will be about $800 million in 1979, with the States spending about 93 percent of that total. In addition, in fiscal 1978, approximately $400 million of title XX funds were spent for protective services provided to children and families without regard to income. Other title XX services would also meet the definition of title IV–B child welfare services.

Most of the expenditures reported under the title IV–B program were to provide foster care, including income maintenance for children who are ineligible for foster care under the AFDC program. According to HEW statistics, about 3 percent of the total Federal, State and local funding is used for adoption services, 8 percent for day care, 73 percent for foster care, 8 percent for protective services, and the remainder for a variety of other child welfare services. (See table 7.)

In hearings on the child welfare services program in 1977 and again this year, the Subcommittee on Public Assistance and Unemployment Compensation received extensive testimony on the need to improve the quality of services available to families and children. The testimony made clear that there is a need not only for improved Federal funding, but also for new requirements in the law to assure that State programs include a variety of services to prevent the need for foster care, as well as to protect children who, despite such services, nonetheless must be placed in foster care.

Section 103.—Extension of grants for hiring welfare recipients as child care workers

Section 103 permits States to use their share of the $200 million available for child care services under this bill for grants to employers who hire welfare recipients as child care workers. Such grants may be used to reimburse up to $5,000 a year of the wages of an eligible welfare recipient (as defined by section 50B(h) of the Internal Revenue Code of 1954) working in a public or nonprofit private facility and up to $4,000 a year of the wages of a welfare recipient employed by a profit-making facility. (The differential takes into account the availability of a tax credit for proprietary facilities.) To qualify, the child care facility must be one in which at least 20 percent of the children receiving services at the facility have their care paid for through the State title XX program.

For fiscal year 1977, Public Law 94–401 made available $200 million in non-matched Federal funds for child care services and authorized States to use such funds to reimburse employers who hired welfare recipients for child care jobs. The $200 million made available for 1977 was extended for 1978 and 1979. The authority to use such funds to hire welfare recipients, however, expired at the end of fiscal year 1978 when legislation to extend such authority, passed by the House and reported by the Senate Finance Committee, was not acted on by the Senate. The bill would restore this expired authority, effective October 1, 1979.

Section 104.—Title XX training funds

Section 104 would limit, for fiscal year 1980 only, Federal matching funds for training to an amount equal to three percent of the State's fiscal 1980 allotment of Federal funds under the title XX statutory ceiling. Where a State received more training funds in fiscal year 1979 than the amount equal to three percent of its fiscal 1980 allotment, it would be eligible for an additional amount equal to two-thirds of the amount by which Federal training funds received in fiscal 1979 exceeded three percent of its fiscal 1980 allotment. Beginning in fiscal year 1981, and for each year thereafter, a State would be reimbursed only for those training expenditures that have been included in, and approved by HEW as a part of, a State title XX training plan.

Under current law, States are eligible for 75 percent Federal matching funds for training costs related to title XX activities. These funds are open-ended and are available in addition to matching funds provided under the statutory ceiling. Since fiscal year 1976, the first year of the title XX program, expenditures for State and local training programs have increased from $31 million to an estimated $100 million for fiscal year 1980.

The bill would place a ceiling on training costs for fiscal year 1980. However, to avoid placing an undue burden on those States which spent more for training in fiscal 1979 than they would receive under the three percent limitation for fiscal 1980, the bill allows such States to receive an additional amount in fiscal 1980 equal to two-thirds of the difference between their fiscal 1979 expenditures and the three percent limit for fiscal 1980. As under present law, these funds would

be available in addition to the State's allocation under the statutory ceiling. Table 6, in the Background section, shows estimated Federal expenditures for training under the new formula for fiscal 1980.

For fiscal 1981 and thereafter, in order to be eligible for training funds, a State would have to submit to HEW, for approval by the Secretary, a training plan specifying how its funds will be used for training or retraining. The plan would have to: (1) describe how training needs of the State title XX program are assessed and how the assessment was used to structure the training programs, how the individuals are to be trained, and how training resources are to be utilized; (2) demonstrate that the training activities have a direct relationship to the title XX services program and to the State's staffing needs to carry out the title XX services program; and (3) describe the State's plan to monitor training programs and to evaluate the overall staff training the development program. To the extent possible, the Secretary of HEW should consult with the states in the development of training plan criteria.

The Committee believes that training is an important part of the title XX program. However, the Committee also believes that States should be encouraged to use their training funds more efficiently. Under the bill, States would be required to carefully assess their training needs and to utilize their training resources for the maximum benefit of title XX recipients. Further, the Committee believes that a State should take into account local government social service efforts in determining how training funds should be distributed under the ceiling.

The intent of the State training plan requirement is to assure that training activity receiving Federal aid is of high quality and directly related to the needs of title XX recipients. The Committee has been informed that, in some cases, States have used title XX training funds for purposes only tangentially related to their social services program. The Committee intends that HEW use the State plan approval authority provided under this bill to closely monitor training expenditures and programs to assure their appropriateness.

The Committee believes that, with the objective of improving the quality and delivery of services, greater emphasis should be given to those programs which train or retrain individuals already employed by the State agency or a provider agency, and other individuals actively engaged in the delivery or administration of title XX services. In addition, the Committee requests that HEW review current regulations which restrict the use of Federal training funds on the basis of whether the organization providing the training is public or private, and those regulations which restrict the use of Federal Title XX training funds to the training of specific persons employed by a private provider agency. The purpose of this review is to determine the conditions under which private agencies could be used to provide necessary training programs and the conditions under which training of other private agency personnel might be reimbursed. The results of this review should be forwarded to the Committee as soon as possible.

Section 105.—Consultation with local officials

Section 105 requires States, prior to publication of their proposed title XX plan, to give public notice of intent to consult with the chief

elected officials of the political subdivisions of their State and provide such officials the opportunity to present their views. The principal views of the local officials would have to be included in the proposed title XX plan. This requirement would be effective beginning in fiscal year 1980. For those States that have, at the time of enactment of the bill, published a comprehensive services plan for 1980, the requirement would become effective for the title XX program year beginning in fiscal 1981.

Under present law, a State must publish its proposed comprehensive services plan at least 90 days prior to the beginning of the services program year and receive comments on the annual plan for at least 90 days. There is no specific requirement that the State solicit the views of local officials.

The Committee believes that elected local government officials should be given an expanded role in the planning for and utilization of title XX social service funds. Elected officials are among those persons most aware of problems in the delivery of services at the city and county level. The Committee believes that regular consultation with local officials can improve coordination with other social services and aid in the development of a sound title XX program.

It is not the intent of the Committee to place a new and onerous burden on the States. A number of States already involve local government officials in the title XX process. Some States have procedures for receiving comments prior to publication of their proposed title XX plan not only from local elected officials, but from public and private organizations as well as private citizens. It is the intent of the Committee that, in all States, all organizations and individuals who are involved in the delivery or receipt of services have an opportunity to be involved at the planning stage. Local officials may be included in the hearings process or solicited for written comments on the State's plan.

Section 106.—Multiyear Title XX planning

Section 106 would permit States, beginning in fiscal year 1980, to elect to use either a one, two or three year title XX program period. The Secretary of HEW would have authority to require a State which adopts a program period of more than one year to publish and make information about the plan generally available during the program period.

The intent of this provision is to give a State the opportunity to engage in long-term planning for title XX. The State would, however, continue to have a responsibility to provide information to the public on the development and implementation of the plan. One of the chief objectives of title XX is to promote comprehensive social services planning and coordination of all social services activities within a State. The Committee believes this can be most effectively accomplished if States are given the option of pursuing long-range, as well as short-range, objectives and coordinating State initiatives in interrelated social services activities.

The Committee has received testimony that States often encounter difficulties in planning because State and county units are on different budget cycles. In addition, some States have biennial legislative sessions. The bill would give States more flexibility in synchronizing

their title XX planning with State budget cycles or with State legislative sessions.

HEW is presently considering several methods of providing for public comment and review at regular intervals where a State has elected multiyear title XX planning. Thus, the Committee has left the authority for determining the method of such review with the Secretary.

Section 107.—Plan requirement for distribution of funds within a State

Section 107 requires each State to include in its title XX plan the criteria which it used in determining the nature and amount of services to be provided in each geogrpahic area within the State. Under present law, each State is required to set forth in its title XX plan the geographic areas in which services are to be provided and the nature and amount of the services to be provided in each area. The bill would add a requirement that the State specify those areas which it has determined are in special need of services and delineate the criteria which it used to determine the nature and amount of services needed in a particular area. The purpose of this provision is to make avialable to the public the baiss on which a State determines how it is going to allocate title XX funds within the State. Since most States already use such criteria in making their decisions, the provision will not place a new burden on States, but will require them to disclose the criteria to the public.

The requirement would become effective beginning in fiscal year 1980. For those States that have, at the time of enactment of this bill, published a title XX plan for 1980, the requirement would become effective for the title XX year beginning in fiscal 1981.

Section 108.—Services to alcoholics and drug addicts

Section 108 would reinstate and make permanent, effective October 1, 1979, the temporary provisions of law relating to the use of title XX funds for certain services to alcoholics and drug addicts. These temporary provisions expired September 30, 1978.

Generally, title XX funds may only be used to provide health services if the services are an integral, but subordinate, part of a social service. Title XX funds may not be used for services to persons in medical institutions.

Section 108 would make permanent the provisions of law permitting consideration of the entire rehabilitative process in determining whether medical services provided to addicts and alcoholics are an integral but subordinate part of a social service. Also made permanent are provisions which allow funding for up to seven days of detoxification services provided to alcoholics and drug addicts in medical institutions and which apply the privacy protections of section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

Section 109.—Emergency shelters

Section 190 would permit title XX funds to be used, beginning October 1, 1979, for emergency shelter provided as a protective service to an adult in danger of physical or mental injury, neglect, maltreatment or exploitation. The funds could not be used to shelter any adult individual in excess of 30 days in any six month period.

Title XX funds may currently be used to provide emergency shelter for children only. The service to the child cannot last more than 30 days. Under present regulations, HEW has provided that emergency shelter may be offered for 30 days within any six-month period and those 30 days need not be consecutive. The Committee believes that emergency shelter service also should be available to adults in order to allow family members to remain together as well as to provide necessary protection to an endangered adult family member.

Section 110.—Title XX goals

Section 110 adds language stating that it is the purpose of title XX to meet social services needs which are not otherwise being met, in order to make a comprehensive range of social services available under this title, by furnishing services within the State, and especially within the political subdivisions of the State having a special need for those services.

Under current law, States are encouraged to use title XX funds to furnish services directed at five goals including, among others, encouraging an individual's financial self-support, preventing neglect and abuse of children and adults, and reducing the need for institutionalization. This section adds language to encourage the States to provide a comprehensive range of services throughout the State under title XX, but especially in those areas having special need for such services. This provision is not intended to redirect funds away from worthwhile existing services nor to alter the current thrust of the title XX program. Rather, the provision is meant to underscore the support of the Committee for the development of comprehensive State title XX program.

Section 111.—Social services entitlement for Puerto Rico, Guam, and the Northern Mariana Islands

Section 111 establishes a separate title XX entitlement, beginning in fiscal 1980, for offshore areas in the following amounts.

	Millions
Puerto Rico	$15.0
Guam	.5
Virgin Islands	.5
Northern Mariana Islands	.1
Total	16.1

Under the title XX social services program, Puerto Rico, Guam and and the Virgin Islands receive an allotment for social services only from amounts that the States and the District of Columbia certify, after the beginning of the program year, they will not need for the formula allotments for that year. Such an allotment cannot exceed $15 million for Puerto Rico, and $500,000 each for Guam and the Virgin Islands. The actual amount available to the offshore areas is not known until at least three months after the beginning of the fiscal year. As a result, the offshore areas have been seriously limited in their ability to plan for the most efficient use of their social service funds.

The Committee has received testimony that, in fiscal 1979, allotments to the offshore areas may be substantially reduced due to increased expenditures by the States under title XX. The separate

entitlement created by this bill for Puerto Rico, Guam, the Virgin Islands and the Northern Mariana Islands would insure that these areas receive timely and predictable title XX funds.

TITLE II—CHILD WELFARE SERVICES

Section 201.—Amendments to child welfare services program general discussion

When the Social Security Act was passed in 1935, it provided Federal funding for child welfare services "for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent." The original authorization was $1.5 million, to be used by the States in carrying out their plans for services to children in predominantly rural areas and other areas of special need. The law has been amended many times in the succeeding years. Funding levels have been increased, the rules for allocation of funds to the States have been changed, and the purpose of the legislation has been broadened.

The child welfare amendments contained in this bill would consolidate, restate, and, where necessary, modify the existing child welfare provisions of Title IV–B. The bill describes a comprehensive set of child welfare services, procedures and safeguards which the Committee expects all States to implement within the next several years. Provisions in the bill which increase Federal funds for child welfare services and AFDC foster care are structured with the intent of both providing States with some additional resources to assist them in implementing the described services, procedures and safeguards and providing financial incentives to implement them as quickly as possible.

The initial increase in Federal IV–B funds is intended to enable States to immediately review the status of all children who have been in foster care for over six months. The first allocation of new IV–B funds will also enable States to put in place most of the services, protections and procedures described in the bill. When a State has implemented all the services, procedures and protections, except for preplacement preventive services, it may begin receiving Federal matching funds for AFDC-eligible children who, prior to the enactment of the bill, were placed in foster care without a judicial determination. In addition, the State would qualify for its share of the second allocation of the new IV–B child welfare services funds.

In order to continue receiving any of the new IV–B funds, a State would have to implement all the services, protections and procedures within a specified period of time after it received its share of the second allocation of the new funds. Once a State had implemented all the required services, protections and procedures, in addition to maintaining eligibility for receipt of the new IV-B funds, it could qualify for Federal matching funds for AFDC-eligible children "voluntarily" placed in foster care at the specific written request of the parents.

The changes made by the bill and the reasons for these changes are further elaborated below.

Establishment of a $266 million child welfare services entitlement program

Under present law, Title IV–B of the Social Security Act authorizes $266 million in Federal matching funds for a wide range of child

welfare services and for foster care payments. In fiscal 1979, the IV–B authorization for child welfare services was funded at $56.5 million. Section 201 would replace the present IV–B authorization with a child welfare services entitlement program for States, subject to a ceiling of $266 million.

The Committee believes that the additional resources provided by this section are necessary to improve the child welfare services and foster care programs in the States. Additional Federal funds will also be needed to enable the States to implement the foster care protections and child welfare services described in this bill.

Title IV-B, which authorizes Federal funds for child welfare services, was intended to complement the program of Federal matching funds for AFDC foster care payments under title IV–A. However, while Federal IV–A foster care funds for children placed outside their own homes are available to States on an open-ended entitlement basis, Federal IV–B funds, which were intended to be used to prevent the need for foster care, to reunify families and to find permanent homes for children, are severely limited. The Committee believes that child welfare services, like foster care payments, should be funded as an entitlement to States, with a ceiling of $266 million.

The full amount of the entitlement would become available to the States in two stages. This funding procedure is intended to assure that States put into place the child welfare protections and services described in this bill before becoming eligible for the full amount of new funds. Moreover, the procedure reflects the concern of the Committee that the States be given time to plan carefully the use of the expanded funding and develop a foster care system that has all the elements described in this bill implemented in a manner consistent with the needs of the State. The bill provides that the new funds would be available to the States in two allotments:

(*1*) *First Allotment.*—Beginning in fiscal year 1980 (October 1, 1979), 40 percent of the new IV–B funds ($84 million) would be available to States to enable them to improve and expand their IV–B services and to complete case reviews on all children in foster care. In order to continue receiving its share of the first allotment beyond fiscal year 1981, a State would have to have in place all the foster care safeguards, procedures and services, except the preplacement preventive services (section 424(c)(1)), that are required under Section 424 of the Social Security Act, as amended by this bill. (Described in "*Foster Care Protections, Procedures and Services*", below.)

(*2*) *Second Allotment.*—Beginning in fiscal year 1981 (October 1, 1980), a State would be eligible for its share of the remaining 60 percent of the new IV–B funds ($125.5 million) after the State had (1) completed case reviews of all children who have been in foster care for over six months and submitted a report to the Secretary of HEW based on this review; and (2) implemented the foster care safeguards, procedures, and services, except the preplacement preventive services (section 424(c)(1)), required under section 424. Such a State would have to have implemented the required preplacement preventive services by the end of the fiscal year following the fiscal year in which it began receiving its share of the second allotment in order to continue receiving second allotment funds. In addition, beginning in fiscal year 1981, in the case of any State which the

Secretary determines has complied with all the foster care protections referred to above (excluding preplacement preventive services), at least 40 percent of any funds received by the State in excess of the amount received in 1979 must be used for services to help children remain with their families and to help children, where appropriate, to return to families from which they have been removed.

Any State which failed to place in effect the regulations, standards, practices, and procedures described in section 424 (excluding preplacement preventive services) prior to fiscal year 1982 would not be eligible in 1982, and years thereafter, to receive either its first or second allotment funds until such regulations, standards, practices, and procedures were placed in effect. Additionally, in order to receive any IV–B funding above its fiscal 1979 level for fiscal year 1982 and subsequent years, a State would be required to submit annual reports to the Secretary of HEW based on detailed case reviews of children in foster care. In this report the State would be required to set forth the number of children who have been in foster care for more than six months and the length of time they have been in oster care, their ages and appropriate demographic characteristics, their legal status, the reasons for initial placement in foster care, the types of foster care arrangements in which they reside, and the numbers of such children respectively expected to return to parents or other relatives, to be adopted, or to have legal guardians appointed.

allocations and matching requirements

Under current law, the Federal matching rate for a particular State is based on per capita income and the number of children under age 21. In no case is the Federal matching less than 33⅓ or more than 66⅔ percent. From the amount appropriated, each State receives a uniform grant of $70,000 a year, plus an additional amount which varies directly with the number of children under age 21 and inversely with average per capita income.

Under the Committee bill, the present Title IV–B formula for allocation of funds to States based on the number of children under 21 and per capita income of the States would be retained. However, the State matching requirement in IV–B would be changed to 25 percent. The Committee has received testimony from the Administration that the States will have no difficulty in meeting the 25 percent matching requirement. At the present time most States are spending far in excess of that amount on child welfare services, and, in fact, the Federal contribution to State child welfare services generally is estimated at about seven percent of total State expenditures for such services. The Committee believes that States should share in the costs of child we fare services to assure that the program continues as a joint Federal-State responsibility.

The bill also provides that, if the appropriations act so provides, any IV–B funds a located to a State for fiscal year 1980 will remain available for use by the State in 1981.

Revised definition of "child welfare services"

Child welfare services are defined in present law. section 425, to mean "public services which supplement, or substitute for, parental care and supervisory for the purpose of (1) preventing, remedying, or assisting in the solution of problems resu ting in the neglect, abuse,

exploitation, or delinquency of children; (2) protecting and caring for homeless, dependent, or neglected children; (3) protecting and promoting the welfare of children of working mothers; and (4) otherwise protecting and promoting the welfare of children, including the strengthening of their own homes, or where needed, the provision of care in foster family homes or day care or other child care facilities."

Under the Committee bill, the definition of "child welfare services" would be modified to read: "child welfare services means public social services which are directed toward the accomplishment of the following purposes: (1) protecting and promoting the welfare of all children, including hand capped, homeless, dependent, or neglected children; (2) preventing or remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation, or delinquency of children; (3) preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family where the prevention of child removal is desirable and possible; (4) restoring to their families children who have been removed, by the provision of services to the child and the families; (5) placing children in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate; and (6) assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption."

The new definition more nearly reflects the current and intended role of title IV–B funded child welfare services by removing the separate references to children of working mothers and the use of title IV–B funds for foster care payments. The new definition specifically mentions handicapped children in need of child welfare services, thereby recognizing special needs created by mental or physical handicapped conditions. The new definition also suggests a hierarchy of objectives beginning with the prevention of child abuse or neglect or amelioration of other family problems, and emphasizes the role of child welfare services in preventing the removal of children from the home, restoring children to their natural home, and finding appropriate adoptive parents if restoration to the home is not possible.

Strengthening child welfare services State plan requirement

In present law there is a requirement that a State have a plan pertaining to the use of title IV–B funds which is to be developed jointly with HEW. The present plan requirement deals primarily with certain administrative mandates which the State must adhere to. The Committee bill would strengthen the State plan requirement under title IV–B by mandating that the State plan contain a description of the services that will be provided, a staff development plan, and an explanation of the steps the State will take to accomplish the purposes of title IV–B and to expand the scope and recipients of available child welfare services.

The Committee believes that there should be greater accountability of the funds provided for child welfare services than presently occurs under the title IV–B program. This is necessary to insure that increases in Federal funds not be used to substitute for current State and local expenditures and to place emphasis on preventive services and alternatives to indefinite placement in foster care.

Essential to the accomplishment of increased accountability will be aggressive Federal leadership by HEW in the development with the States of a title IV–B child welfare services plan. In order to accomplish the maximum impact from the infusion of an additional $209 million of Federal funds into the child welfare services program, it will be essential that States evaluate their present allocation of Federal, State and local resources for child welfare services as well as their present administrative structure, and not simply add new funds on top of the child welfare system already in place.

The Committee recognizes that measurable improvements in the impact of child welfare programs on the well-being of children will not be quickly realized. The time needed to develop comprehensive emergency, preventive and restorative services, to up-grade staff, to find and license appropriate foster care homes, as well as the time needed for legal procedures and casework in the adoption of a child, preclude sudden improvements. However, it is expected that the States will effectively use their new funds to accomplish measurable improvement over a reasonable length of time.

As noted above, under the new title IV–B State plan requirements, the State must provide a description of its child welfare services staff development and training plan. Because of the critical nature of the tasks and responsibilities of child welfare workers as they affect the lives of children, such tasks must be handled with maximum competence. HEW should assume a key leadership role in assisting the States to formulate a child welfare services staff development and training plan. Such plans could include: a staff recruitment and selection plan; development of an in-service training program; training of foster care providers; and joint training efforts with schools and universities. The child welfare services staff development and training plan should be developed in conjunction with the title XX training plan. It is the intent of the Committee that this portion of the title IV–B plan requirement could be met if it is made a part of the title XX training plan. The new foster care protections required by this legislation may require special efforts in staff training that will be made possible by the additional title IV–B funds.

States would also be required to provide in their plans for the coordination of the services provided for children under the title IV–B plan and the services and assistance provided under title XX, under the AFDC foster care program, and under other State programs having a relationship to the child welfare services program.

Limitations on use of Title IV–B funds

The bill provides that a State could not receive more Federal title IV–B funds for adoption assistance payments, foster care maintenance payments, and employment-related child day care services than the State's total allotment for title IV–B in the fiscal year 1979. This limitation was adopted by the Committee in order to emphasize preventive, restorative, adoptive and other types of child welfare *services*, and to insure that the additional title IV–B funds are used to expand such services. With respect to the limitation on employment-related child day care services, the Committee believes that, although child day care is a legitimate and necessary element of a child welfare program, its basic purpose in the context of such a program should be

to protect and promote the welfare of children and not to enable parents to work or train for employment. The Committee intends that title IV–B funds be used for child day care as a part of a protective services program, such as for children who have been identified as victims of abuse or neglect and for whom a special day care program is needed. It is also intended that handicapped children served through the child welfare services system may receive special services through a child day care program because of their handicapping conditions; but it must be related to the special needs of the child and not the need of the parent for day care for employment purposes. The Committee points out, in addition, that any child day care service provided with title IV–B funds would have to meet the same requirements for such care as are provided under the title XX social services program.

To prevent the substitution of new Federal funds for existing State expenditures, the bill would prohibit States from spending less for child welfare services under title IV–B and under title XX (excluding employment-related day care, adoption assistance payments, and foster care maintenance payments) than the total amount of State expenditures for such services in 1979.

Required foster care protections, procedures, and services

The bill establishes a comprehensive set of child welfare services, procedures and safeguards which when fully implemented would protect children and families against unwarrented removal of children from their homes and inappropriate and unnecessarily prolonged foster care placement. These protections, procedures and services would provide: (1) that no child will be placed in foster care, except in emergency situations, either voluntarily or involuntarily, unless services aimed at preventing the need for placement have been provided or refused by the family; (2) that no child will be involuntarily removed from his or her home, except on a short-term basis in emergency situations, unless there has been a judicial determination that the child should be removed; (3) that no child will be placed in foster care by the voluntary action of his or her parents unless a "voluntary placement agreement" has been signed by parents and agency; (4) that a child who has been removed from his or her home will be placed in the least restrictive family-like setting in which any special needs may be met, within reasonable proximity to his or her family and with relatives where appropriate; (5) that reunification services are made available to the child and his or her parents after removal from the home; (6) that there will be a written individualized case plan developed for each child placed in foster care, and a system of case review that assures that each child receives a case review at least every six months; (7) that there be a dispositional hearing by a court or court appointed administrative body within 18 months of the child's placement; and (8) that a fair hearing be provided for any parent, foster parent, guardian or child who believes he or she has been aggrieved by any governmental action taken under this section.

In order for a State to be eligible to receive on a permanent basis its second allotment funds, or, in other words, to maintain eligibility for its full share of the $266 million in child welfare service funds, the Secretary of HEW would have to determine that the State has in operation all the protections, procedures and services listed above.

The purpose of this provision is to require States to make critically needed improvements in their foster care programs. The required foster care safeguards, procedures and services are intended to provide children and families with improved protection against unwarranted removal of children from their homes and added protection against inappropriate and unnecessarily prolonged foster care placement. The major objectives of this provision are to establish the placement and review procedures and services that will prevent children from "getting lost" within the foster care system, and promote the permanent placement of children with families.

Although foster care placements are intended to be temporary, children tend to remain in placement for long periods of time and may change foster homes two or three times. According to the *National Study of Social Services to Children and Their Families*, conducted in 1977 for the Department of Health, Education and Welfare, all children in foster care had spent a median of two and one-half years in foster care. The study found that 48 percent of all children in foster care had been in placement for more than two years. More detailed findings of the study on the length of time children had been in foster care are as follows:

Years	Number of children	Percentage
Total over 2 years	238,401	48.0
2 to 3	83,836	16.7
4 to 5	48,951	9.8
6 to 8	33,371	6.7
8 or more	72,243	14.4

It will be necessary for HEW to assess the States' "laws, regulations, standards, practices and procedures" to determine that the foster care protections required by this section are operational in the State. This assessment should not be restricted to the evaluation of a written statement of intent by the State or a review of completed forms or individual service plans contained in a State's files. The determination will have to be made in order for a State to receive its full share of the $266 million in Federal title IV–B funds. This determination will also have to be made before a State could receive Federal matching funds for AFDC children who are voluntarily placed in foster care without a judicial determination, as provided under Section 301 of this bill.

The foster care protections that a State must have in place in order to be eligible to receive its full title IV–B entitlement, under the allotment procedures set out in the bill, are discussed more fully below.

A. PREVENTIVE SERVICES REQUIREMENT

In order to protect children from being unnecessarily removed from their homes and placed in foster care, the amendments would require (as a condition of full title IV–B funding on a continuing basis, as described above) that preventive services must first be made available to the child and the family. These services may include, for example, homemaker services, day care, twenty-four hour crisis intervention,

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emergency caretaker services, emergency temporary shelters and group homes for adolescents, and emergency counseling.

Under the bill, States would have to have in effect such laws, regulations, standards, practices and procedures, approved by the Secretary, as are necessary and appropriate to assure that no child will be placed in foster care unless the child and his family have been provided adequate preventive services designed to avoid out-of-home placements. However, the Committee recognizes that the preventive services requirement would be inappropriate in certain specific circumstances. This would be the case where the home situation presents a substantial and immediate danger to a child which would not be mitigated by the provision of preventive services. In this case the amendments would allow placement without prior provision or offering of preventive services, regardless of whether there had been a judicial determination. In addition, when there has been a court determination that a child has committed a delinquent offense (considered for purposes of this legislation as an offense which would be a criminal offense if the child were an adult), the preventive services requirement would not apply.

The Committee recognizes that the entire array of possible preventive services are not appropriate in all situations. The decision as to the appropriateness of specific services in specific situations will have to be made by the administering agency having immediate responsibility for the care of the child.

B. INVOLUNTARY PLACEMENT

The bill would prohibit the involuntary removal of a child from a home shared with a parent and placed in foster care, unless there has been a judicial determination that: (1) the situation in the home presents a substantial and immediate danger to the child which would not be mitigated by the provision of preventive services; (2) the child is dependent, neglected, or in need of supervision or has committed a status offense, and preventive services have been provided but have failed to alleviate the crisis or have been refused by the family, or every reasonable effort has been made to provide such services; or, (3) the child has committed a delinquent offense. However, the bill would allow placement in foster care on a short-term emergency basis without a judicial determination in the case of: (1) a situation in the home which presents a substantial and immediate danger to the child which would not be mitigated by the provision of preventive services; (2) an alleged delinquent; or, (3) an alleged status offender. State laws dealing with abuse, dependency or neglect vary with regard to the conditions under which children may be removed from their home on an emergency basis. However, most States which address the issue require that a petition be filed with a court within 24 to 72 hours. The Committee believes that any extension of this emergency exception beyond 72 hours can only be justified in very unusual circumstances.

C. VOLUNTARY PLACEMENT

The bill would provide for the voluntary placement of a child in foster care by the parent only if a written voluntary placement agreement has been developed and approved by the placement agency and

the parents. A voluntary placement agreement is defined in the bill as a written agreement, binding on the parties to the agreement, between the agency and the parents or guardians of a minor child, which specifies, at a minimum, the legal status of the child and the rights and obligations of the parents, the child, and the agency while the child is in placement.

D. PLACEMENT OF CHILDREN IN FOSTER CARE

In those cases where preventive services cannot alleviate the need for placement, the Committee bill provides that a child be placed in the least restrictive setting in which his special needs, if any, may be met; with relatives, if appropriate; and within reasonable proximity to his natural family, taking into account his special needs.

Children who enter care are too often inappropriately placed in institutions when their needs could better be met in less restrictive settings, including foster family homes and group homes. The Committee recognizes that, in order to appropriately meet the needs of children, different types of foster care placements must be established which provide a range of services designed to meet the needs of the children in care. A continuum of placements ranging from least restrictive to most restrictive would include at a minimum the following: foster family homes; group homes and community residences; residential treatment centers and child care institutions.

It is expected that some of the additional funds provided to States under Title IV–B will be used where needed to develop those foster care placement settings, such as foster family homes, which will bring States into compliance with the requirement that a child be placed in the least restrictive setting in which his or her needs may be met. HEW's joint efforts with a State to develop the Title IV–B State plan should take into account both Federal and State evaluation of the resources in the State for least restrictive placement.

State development of less restrictive placements should take into account that the special needs of mentally and physically handicapped children and emotionally disturbed children can often be met in foster family homes if the foster parents are capable, by virtue of special training or experience, of providing the needed services. Title IV–B funds can be used, under the same limitations and restrictions as in Title XX law and regulations, to train and compensate foster parents for those special services which they provide beyond room, board, care, and supervision which constitute basic foster care. In providing special needs services, the child welfare agency may need to develop appropriate agreements and arrangements with other agencies that have specific professional expertise in serving such children for the development of the case plan, training of foster care providers, and providing or supervising the provision of special services.

A child's chances of being reunited with his family are usually reduced when he is placed at great distances from his family and home community. Studies have shown that parent-child contact is often the only significant indicator of the potential for a child's being returned home once in care. Yet, many children are placed in distant placements which effectively preclude the child from maintaining

communication, or, in many instances, any relationship with his family. The bill would require that children in foster care be placed within reasonable proximity to their families, taking into account any special needs they may have. The Committee intends that children ordinarily be placed in or very near their home communities.

The bill requires that a child be placed with relatives, if appropriate and reasonably possible. Consideration should be given to whether a child might have relatives who would be available as foster parents, since relatives may serve as foster parents under the Federally reimbursed foster care program. Placement with relatives could help enhance the possibility that a child will ultimately be able to return home and would allow some continuity for the child during the period of separation.

E. FAMILY REUNIFICATION SERVICES

Too often children are placed in foster care indefinitely without an aggressive effort to provide services to reunite them with their families. The bill would require that family reunification services be made available to children in foster care and their families to alleviate the conditions necessitating placement and to enable the child to return home as quickly as possible. The Committee believes that family reunification services should include a range of services designed to enable the child to return and remain at home. Such services could include transportation services, family and individual therapy, psychiatric counseling, homemaker and housekeeper services, day care, consumer education, respite care, information and referral services, and various transition and follow-up services.

F. REQUIREMENTS FOR AN INDIVIDUALIZED CASE PLAN, REVIEW OF EACH CASE PLAN EVERY SIX MONTHS AND A DISPOSITIONAL HEARING NO LATER THAN 18 MONTHS AFTER PLACEMENT

The Committee has included in the bill the requirement that there be a written individualized case plan for each child in foster care and that there be a case review system under which each child receives a review of his case at least once every six months.

Under the bill, the case plan must be a written document which includes at least the following information: a description of the type of home or institution in which the child is to be placed, including a discussion of the appropriateness of the placement and (if the child was removed as a result of a judicial determination) how the agency which is responsible for the child proposes to comply with any requirements set as a result of the judicial determination; and a plan of services that will be provided to the family, child and caretaker in order to improve the conditions in the home, facilitate return of the child or the permanent placement of the child, and address the needs of the child while in foster care, including a discussion of the appropriateness of the services that have been provided to the child under the plan.

The case review provided in the Committee bill must be a review by a court of competent jurisdiction or an administrative review which, at a minimum, verifies that the child has a case plan, and determines the continuing appropriateness or need for modification of the case

plan and the extent of compliance with the case plan; evaluates the continuing necessity for and appropriateness of the placement and the progress made toward eliminating the need for placement in foster care; and sets a date by which it is expected that the child can be returned home, freed for adoption, or otherwise permanently placed. If the review is an administrative review, it must be impartial, open to the participation of the parents and caretakers of the child, and be conducted by a panel of appropriate persons, at least one of whom is not responsible for the case management or delivery of services to the child or the parents.

The Committee recognizes that because "administrative review" is a process established and conducted by the State, the panel of "appropriate persons" should be designated according to the laws and regulations and policies governing such processes within each State.

In addition, the Committee has included a provision establishing that a mandatory dispositional hearing be conducted within eighteen months of the original placement of the child in foster care. This hearing must be held in a family or juvenile court or other court of competent jurisdiction, or by an administrative body appointed by a court. The Committee is aware that many children, because of the inadequacies of current review procedures, and lack of family reunification services, become "lost" in foster care, and continue to remain in care unnecessarily at great cost to the government, themselves and their families. The purpose of this dispositional review is to identify children who have been in placement a substantial period of time and to assess the appropriateness of their placement. The review must determine whether the child should be returned to his or her home; whether the child requires continued placement for a specified period not to exceed six months, except where the court or administrative body determines there are special circumstances which prevent immediate return to a parent; whether the child should be placed with a legal guardian; whether proceedings should be initiated to terminate parents' custody rights so the child can be free for adoption; or whether a child should be placed in permanent long-term foster care placement because the child cannot or should not be returned home or placed in an adoptive home.

Studies have shown that most children who remain in foster care for more than eighteen months are likely to remain in such placement until majority, regardless of whether such continued placement is the most desirable option for the particular child. The Committee is concerned that foster care in these cases becomes a long-term holding situation rather than a short-term program as it was originally conceived. Long-term foster care should be regarded as an option only when neither a return to the family nor adoption is possible.

G. FAIR HEARING PROCEDURE

The bill would provide a fair hearing procedure whereby any parent, guardian, foster parent or child who believes that he or she has been aggrieved by any governmental action under the foster care protection provisions will be afforded a fair hearing before an impartial hearing officer who has not been involved in the care and supervision of the child. Each individual involved must be given notice of the hearing and be allowed to participate.

The Committee intends that fair hearings be held and disposed of promptly. In scheduling hearings, the Committee believes that reasonable attempts must be made to conduct such proceedings at a time and place which is convenient to all of the parties involved.

TITLE III—FOSTER CARE AND ADOPTION ASSISTANCE

General Discussion

Section 408 of the Social Security Act requires all States to provide foster care as a component of the State's AFDC program. Under the AFDC foster care (AFDC–FC) program, Federal matching funds are available on an open-ended entitlement basis for children who meet the eligibility requirements specified in Federal law. Eligibility is limited by the requirement that the child: (1) was either receiving AFDC, was eligible to receive AFDC, or lived with a specified relative and received or would have been eligible to receive AFDC within the preceding six months; and (2) was removed from the home as a result of a judicial determination that continuance in the home would be contrary to his or her welfare for any reason. Present law requires that an individual plan be developed for each child in foster care to assure that he or she receives proper care and that services to improve the home conditions or make possible placement with a relative are provided. The need for foster care must be reviewed periodically.

The Committee bill broadens the definition of children eligible for foster care to include needy children who are voluntarily removed from their homes and placed in foster care by their parents or guardians.

Section 301.—Federal payments for children voluntarily placed in foster care

Section 301 of the Committee bill would allow Federal matching for foster care in the case of an AFDC child removed from his or her home without the judicial determination required under present law. However, the removal would have to be voluntary and at the specific written request of the parents or legal guardian. Federal AFDC foster care funds would be available for foster care payments for an AFDC-eligible child who had been removed from his or her home pursuant to a voluntary placement agreement after the Secretary had determined that a State had in place the protections, procedures, and services required under section 424 of the Social Security Act, as amended by this bill.

The requirements imposed on States by section 424, as amended by section 201 of this bill, include the following:

No child will be placed in foster care, except in emergency situations, either voluntarily or involuntarily unless services aimed at preventing the need for placement have been provided or refused by the family;

No child will be involuntarily removed from his home, except on a short-term basis in emergency situations, unless there has been a judicial determination that the child should be removed;

No child will be placed in foster care by the voluntary action of his or her parents unless a "voluntary placement agreement" has been signed by parents and agency;

A child who has been removed from his or her home will be placed in the least restrictive family-like setting in which any special needs may be met, within reasonable proximity to his or her family, and with relatives where appropriate;

Reunification services are made available to the child and the parents after removal from the home;

There will be a written individualized case plan developed for each child placed in foster care, an administrative review of each case plan at least every six months, and a dispositional hearing by a court or a court appointed administrative body within 18 months of the child's placement; and

A fair hearing will be provided for any parent, foster parent, guardian or child who believes he or she has been aggrieved by any governmental action taken under section 424.

The Committee believes these protections are necessary because of deficiencies in the current State child welfare and foster care programs. They are intended to provide children and families with improved protection against unwarranted removal of children from their homes and added protection against inappropriate and unnecessarily prolonged foster care placement.

Testimony received by the Committee recommended that the judicial determination requirement in the present IV-A foster care program be waived if the child is removed from his or her home and placed in foster care at the request of the parent. It was argued that, in the case of a voluntary request for placement, judicial determination can sometimes be inappropriate and detrimental. The Committee was informed that unnecessary court proceedings place stress on the family and may result in a traumatic experience for the child. However, because at the present time there must be judicail determination in order to qualify for Federal foster care matching funds under IV-A, there is a strong financial incentive to take all voluntary cases to court for the sole purpose of qualifying for Federal funds. According to the testimony, many States are now sending all their AFDC eligible children through an essentially *pro forma* court proceeding in order to maximize Federal funds needed to meet the growing costs of foster care. Witnesses claimed that this was wasting the time of the court and the caseworker, and ncreasing the total cost of foster care

Based on this testimony, and with the new foster care protections required under this bill, the Committee believes that it is appropriate to waive the judicial determination requirement in those cases where the AFDC child is removed from his or her home and placed in foster care voluntarily and at the specific written request of tbe parents or legal guardian. In order to provide necessary protections for the family and the child placed in foster care on a voluntary request basis, Federal matching funds would not be available for an AFDC child removed from his or her home without the judicial determination required under Section 408 until the State had implemented the foster care protections required under Section 424, as amended by this bill. A court determination would still be necessary to remove a child where there was no specific written request from the parent.

The Committee was informed that there are AFDC-eligible children in foster care who have been placed voluntarily, without a judicial determination. These children are not receiving Federal matching

funds under the IV–A foster care program. Section 301 of this bill amends the present foster care provision to allow an AFDC-eligible child who was removed from his or her home without a judicial determination prior to the date of enactment to become eligible for Federal AFDC matching funds for future foster care payments and adoption assistance payments provided by this bill (1) after the state had implemented all the foster care safe guards, procedures and services, except for the preplacement preventive services (section 424 (c) (1)), required under section 424, and (2) after a written individualized case plan had been prepared for the child and reviewed in accordance with the requirements of Section 408 (e) (2), as amended by this bill.

It is the Committee's belief that AFDC-eligible children who are now in foster care as a result of voluntary placement should, under certain conditions, be eligible for Federal reimbursement and, most important, that the protections and procedures contained in this legislation should apply to these children. Before Federal matching funds become available to children who have been voluntarily placed in foster care without judicial determination, the State must develop a written individualized case plan for each child, and the plan must be reviewed by an experienced, objective person not directly involved in the provision of services to the family. Such person should be designated by the State or local government administrating agency most directly responsible for the child. The review may be conducted by a court of competent jurisdiction. The bill specifies that the reviewer must comply with the following procedure and include in the written report the following information:

The reviewer must determine the extent of progress which has been made toward alleviating or mitigating the causes necessitating placement, and project a likely date by which the child may be returned to the home of his or her biological parent or parents.

The reviewer must insure the compliance by all parties with the requirements of the case plan and voluntary placement agreement, where such an agreement has been executed, and modify those documents where necessary;

The review must be conducted no less than two weeks after the parent and the child have been notified in writing of the review, advised of the status of the case and agency recommendations, and provided the opportunity to appear by or with representation of their choice;

The review must result in written findings and conclusions and, if necessary, modifications in the case plan which shall specify the obligations and duties of all the parties during the continued period of placement, a copy of which must be provided to the agency and to the child's biological parent and guardian, foster parents, or any other party having responsibility for the maintenance of the child;

The review requirements specified in this section are intended to be the minimum requirements. Where the State has performed a review under its own procedures prior to the time this bill becomes effective, that review will suffice if it is equivalent to or more comprehensive than the review required under this section of the bill;

Federal payment for foster home care of dependent children in certain public institutions

The bill expands the definition of the type of child care institutions eligible to receive Federal foster care matching funds on behalf of eligible foster care children to include public institutions or group homes which care for 25 or fewer children. Under present law, Federal IV–A matching funds for foster care are provided only for children in nonprofit private institutions.

The purpose of this amendment is to provide an additional option for the States as they develop a broader range of foster care settings. Authorizing AFDC foster care payments in such settings will require more diligent efforts by HEW and the States to insure that a child is placed in the least restrictive setting where his needs can best be met and which resembles as closely as possible a family setting.

The amendment would continue to disallow foster care payments for children placed in large public institutions even though a wing of the institution, a dormitory, or a cottage on the grounds of the institution may have 25 or fewer residents. The intent of this provision is to encourage the placement of children in community-based facilities whenever it is appropriate to the special needs of the children involved.

The additional facilities in which children may be placed under this bill include facilities operated by public agencies which house 25 or fewer children and are variously defined by the States to include group homes, group residences, group facilities or residential treatment facilities. Foster care payments would not be available for children placed in detention facilities, forestry camps, training schools and other public facilities operated primarily to accommodate delinquent children. Concern was expressed during committee hearings about the proposed maximum size of 25 for such public foster homes as exceeding the generally recognized standards for a foster group home. The number 25 is intended to be a maximum and is not intended to convey a preference of the Committee for facilities of that size. It is the intent of the Committee that the quality of care and services provided in public institutions be comparable to that provided in private nonprofit institutions.

Section 302.—Adoption Assistance Payments under the Aid to Families with Dependent Children Program

Section 302 of the bill requires States to include an adoption assistance program as part of their Aid to Families with Dependent Children (AFDC) program. Under current law, Federal AFDC matching funds are not available for adoption assistance. The assistance authorized by this section could be provided on behalf of an AFDC foster care-eligible child or an SSI-eligible child who has been determined by the State to have "special needs." Federal matching funds for adoption assistance payments for both AFDC and SSI-eligible children would be paid from Federal AFDC funds.

"Special needs" would exist when the State has determined (1) that the child cannot or should not be returned to his own home; (2) that there is a specified condition (such as age; physical, mental, emotional, or medical handicap; or membership in a minority or sibling group) because of which it is reasonable to conclude the child cannot be placed without assistance; and (3) except where it would be against

the best interest of the child, efforts have been made to place the child without providing adoption assistance payments.

The Department of Health, Education, and Welfare estimates that there are between 90,000 and 100,000 children currently in the AFDC foster care system who are legally eligible for adoption. Approximately 8,000 to 10,000 of those children are eligible for adoption assistance because of special needs.

From a recent unpublished study of the characteristics of disabled children receiving benefits under the Supplemental Security Income (SSI) program, the Department of Health, Education, and Welfare estimates that 25,000 of the children receiving SSI are living in some form of "special living arrangement." This means that the children are living away from their parents, but are not in a medicaid institution. Approximately 5,000 of these children living away from their parents are eligible for adoption. The average length of time that these children have lived away from their parents is 7½ years. Their average age is 12½ years. Approximately 60 percent are retarded or have some form of mental disability; 71 percent are white, 23 percent black. HEW also discovered that about 30 percent of the children in "special living arrangements" receive a State-financed foster care payment in addition to their SSI payment. Also, 30 percent receive some social security payments.

The amount of the adoption assistance payments, if any, would be determined by agreement between the adoptive parents and the administering agency, taking into consideration the economic circumstances of the adopting parents and the needs of the child. The amount would be subject to periodic adjustment in accordance with any changes in those circumstances. The amount of the payment could not exceed the amount that would have been paid for foster care for such a child in a foster family home in the State. However, it could initially include an amount to cover the non-recurriug expenses associated with the adoption of the child.

Children for whom adoption assistance payments are made would be eligible for Medicaid on the same basis as AFDC children and AFDC foster care children.

Adoption assistance payments could continue until the child reaches age 18. In the case of a child with a physical or mental handicap, the State could continue assistance until age 21. It would cease before the child reaches age 18 (or 21) if the State determined that the child was no longer receiving any support from the parents.

Many children who are removed from their homes and placed in foster care are never able to return to their homes. It is the position of the Committee that, if the responsible agencies are working in the best interest of foster care children, it is the duty of the agency to provide a permanant home for these children, either through placement in adoptive homes or, when adoption is not feasible, in a permanent family foster care situation. Serious difficulties arise in trying to permanently place children who have special needs. These children include not only handicapped children, but also children who are considered hard to place because of their race, ethnic background, or because they are part of a large sibling group. Attempts to place them in adoptive homes without a subsidy have often failed because many families cannot afford the expense required to adequately meet the special medical or other needs of these children.

The primary objective of this legislation is to promote reforms in State foster care and child welfare services programs that will significantly increase the number of children placed in permanent homes. These reforms would not be complete without the provision of adoption assistance. Children with certain special needs such as a physical or mental handicaps, are often the children most likely to be placed in foster care, many times as a result of problems in the home related to the ability of other family members to cope with their needs. These children also are the ones most likely to remain in foster care in the absence of adoption assistance primarily because of the cost associated with their needs. For the 25,000 SSI children living in some form of special living arrangement away from their parents, the following reasons were given for their out of home placements:

Parent felt emotionally incapable of caring for the children: 49 percent;
Parent did not want child: 17 percent;
Parent ill or disabled: 11 percent;
Other: 12 percent.

The Committee has received testimony documenting the benefits of an adoption assistance program, both in terms of providing a permanent home and family for children currently in foster care and in terms of dollar savings in the AFDC foster care program. On the basis of this and other information indicating the cost effectiveness of adoption assistance programs currently operating in the States, the Committee believes that the establishment of an adoption assistance program for children in AFDC foster care could result in cost savings. The children who will receive this assistance are AFDC children who otherwise would most likely remain in more expensive foster care arrangements.

It is not the Committee's intent to take over adoption assistance programs from the States with this new authority, but to complement and allow for the expansion of existing State efforts.

The amendments made by this section with respect to the establishment of adoption assistance programs in the States would become effective on the first day of any month that a State wished to designate during the period October 1, 1979 and October 1, 1980, but shall, in any event, be effective in all States no later than September 1, 1980.

TITLE IV—MISCELLANEOUS

Section 401.—Public assistance payments to territorial jurisdictions

Section 401 of the bill would make permanent certain temporary changes effective during fiscal 1979. It would make permanent the current 75 percent Federal matching rate for public assistance programs in Puerto Rico, Guam and the Virgin Islands as well as the current $78 million limit on the maximum amount of Federal funding available to these areas: $72 million for Puerto Rico, $2.4 million for the Virgin Islands, and $3.5 million for Guam.

Under the permanent provisions of the Social Security Act (section 1108), which authorizes the funding levels and matching rates for public assistance programs in these offshore areas, the Federal matching rate is set at 50 percent and the yearly aggregate dollar ceiling is set at $26 million. This limit, which was effective from fiscal 1972 through fiscal 1978, covered all cash assistance payments, administrative costs, and social services not covered by title XX.

96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPT. 96-136
1st Session } { Part 2

SOCIAL SERVICES AND CHILD WELFARE AMENDMENTS OF 1979

JUNE 26, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. NATCHER, from the Committee on Appropriations, submitted the following

REPORT

[To accompany H.R. 3434]

The Committee on Appropriations, to whom was referred the bill (H.R. 3434) to amend the Social Security Act to make needed improvements in the child welfare and social services programs, to strengthen and improve the program of Federal support for foster care of needy and dependent children, to establish a program of Federal support to encourage adoptions of children with special needs, and for other purposes, having considered the same, reports favorably thereon, but is concerned with provisions attempting to make these programs "entitlements" since the present situation in this area as pointed out in the report can only destroy the ability of the Congress to establish priorities and control Government spending.

EXPLANATION OF COMMITTEE ACTION

H.R. 3434 was reported from the Committee on Ways and Means on May 10, 1979, and was referred to the Committee on Appropriations on June 6, 1979 for consideration as provided in section 401(b) of Public Law 93-344 (the Congressional Budget Act of 1974).

Section 401(b) provides that when an authorizing committee reports a bill containing entitlement authority and the entitlement authority is in excess of the amount allocated under the budget resolution, the bill shall be referred to the Committee on Appropriations. The Appropriations Committee then has 15 legislative days in which to deal with the bill. The committee's authority over the bill relates only to the cost provisions of the legislation and not to the legislative policy it contains. After 15 days the committee is automatically dis-

charged from further consideration of the bill if no action has been taken.

H.R. 3434 was referred to the Committee on Appropriations because it creates new entitlements which exceed the appropriate allocation of new budget authority reported under section 302 in connection with the First Budget Resolution for fiscal year 1980.

COMMITTEE RECOMMENDATION

The committee reports the bill with the recommendation that the bill do pass. The committee makes this recommendation with some reservation, however. The committee is concerned about the provisions in the bill creating an entitlement for title IV–B, Child Welfare Services. The program was established in 1968 and ever since then has been subject to annual review through normal appropriation procedures. Thus, Congress has had the opportunity to determine the proper spending level each year.

The 1979 appropriation for the child welfare services program is $56,500,000. The bill H.R. 3434 creates a two-stage entitlement providing a level of $140,500,000 in 1980 and rising to a ceiling of $266,000,000 in fiscal year 1981. Congress will be required to provide these amounts in the respective appropriation bills each year.

The committee has no disagreement with the basic purposes of the bill. Rather, it is disturbed with the new entitlement feature proposed in the legislation which tends to aggravate the growing problem of uncontrollable Federal spending generally. Entitlement programs have escalated in the past decade to the point where this year they constitute over 75 percent of the uncontrollable outlays and 55 percent of the total gross budget outlays. The growth in entitlement programs is evident when compared with 10 years ago when they constituted 64 percent of the uncontrollable outlays and only 40 percent of the total budget.

With regard to grants to States for social services under title XX, the committee notes that this program has always been in the form of an entitlement. When first established the entitlement was open ended, but in 1972 Congress established an annual ceiling of $2.5 billion. The bill permanently increases the ceiling to $3.1 billion beginning in fiscal year 1980. If the bill is enacted, appropriations will be required to meet the increased ceiling.

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Calendar No. 352

96TH CONGRESS
1st Session

SENATE

REPORT
No. 96-336

ADOPTION ASSISTANCE AND CHILD WELFARE ACT OF 1979

REPORT

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

together with

ADDITIONAL VIEWS

ON

H.R. 3434, A BILL TO AMEND THE SOCIAL SECURITY ACT TO MAKE NEEDED IMPROVEMENTS IN THE CHILD WELFARE AND SOCIAL SERVICES PROGRAMS, TO STRENGTHEN AND IMPROVE THE PROGRAM OF FEDERAL SUPPORT FOR FOSTER CARE OF NEEDY AND DEPENDENT CHILDREN, TO ESTABLISH A PROGRAM OF FEDERAL SUPPORT TO ENCOURAGE ADOPTIONS OF CHILDREN WITH SPECIAL NEEDS, AND FOR OTHER PURPOSES

OCTOBER 2 (legislative day, JUNE 21), 1979.—Ordered to be printed

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Calendar No. 352

96TH CONGRESS, 1st Session | SENATE | REPORT No. 96-336

ADOPTION ASSISTANCE AND CHILD WELFARE ACT OF 1979

OCTOBER 2 (legislative day JUNE 21), 1979.—Ordered to be printed

Mr. LONG, from the Committee on Finance, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany H.R. 3434]

The Committee on Finance, to which was referred the bill (H.R. 3434) to amend the Social Security Act to make needed improvements in the child welfare and social services programs, to strengthen and improve the program of Federal support for foster care of needy and dependent children, to establish a program of Federal support to encourage adoptions of children with special needs, and for other purposes, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill as amended do pass.

I. Summary

ADOPTION ASSISTANCE, FOSTER CARE AND CHILD WELFARE SERVICES

The committee amendment involves a major restructuring of Social Security Act programs for the care of children who must be removed from their own homes. In particular, the incentive structure of present law is modified to lessen the emphasis on foster care placement and to encourage greater efforts to find permanent homes for children either by making it possible for them to return to their own families or by placing them in adoptive homes.

Subsidized adoptions.—The Committee amendment provides for a new subsidized adoption program with Federal matching. Under the

tives and the shelter allowance for a 6-person family was $60, the amount actually payable for shelter would be $40 (four-sixths of the full allowance). The provision would apply only if the overall household income exceeded the State's AFDC standard of need for a household of that size.

Services for disabled children.—The committee amendment provides for the extension for an additional 3 years of the special referral and services program for disabled children who are receiving SSI benefits. The program was enacted in 1976 and provided up to $30 million in Federal funds to be allocated annually to the States on the basis of the proportion of children under age 7 in the State. Without extending legislation, the program will have expired as of September 30, 1979.

This program requires the referral by the Social Security Administration of a disabled child under age 16 to a State agency which is responsible for counseling disabled children and their families, and for establishing an individual service plan for each child. Children are to be referred to appropriate services, and agencies are required to monitor the program to assure adherence to service plans.

Public assistance expenditures in Puerto Rico, Guam, and the Virgin Islands.—Under existing law there is a dollar ceiling on Federal matching for costs of cash assistance, administration and social services provided under the programs of aid to families with dependent children and aid to the aged, blind and disabled in the jurisdictions of Puerto Rico, Guam, and the Virgin Islands. The annual permanent ceiling is $24 million for Puerto Rico, $1.1 million for Guam, and $0.8 million for the Virgin Islands. These limits have been in effect since 1972. In addition, these jurisdictions are limited to 50 percent Federal matching, whereas the States may receive from 50 to 83 percent Federal matching, depending on State per capita income.

For one year (fiscal year 1979), the overall ceiling was tripled to $78 million and the matching rate was increased to 75 percent by an amendment to the Revenue Act of 1978 (Public Law 95–600). This provision expires September 30, 1979, and the ceiling reverts to $26 million and the matching rate to 50 percent.

The committee amendment provides for a permanent extension of the provisions which were included in Public Law 95–600 on a temporary 1-year basis.

Limitation on Period for State Filing of Claims Under the Social Security Act.—Current law does not set a time limit on State submission of claims under the welfare, Medicaid and social services programs in the Social Security Act. The committee amendment includes a provision under which the Social Security Act would be amended effective October 1, 1981 to limit the period of retroactivity for State claims to a full two years under the various titles of the Act (that is, it would apply to expenditures for periods starting with fiscal year 1980). However, the provision could not be interpreted so as to limit Federal financial participation in cases involving court-ordered retroactive payments or audit exceptions or adjustments to prior year costs. The Secretary of Health, Education, and Welfare would be able to waive the limitation in other circumstances where he determines there is good reason to do so. While this provision establishes a time limitation on claiming reimbursement for expenditures for fiscal 1980 and subsequent years, in the view of the Committee it does not authorize any change in the treatment of outstanding expenditures for

earlier years. The expenditures for such earlier years retain their status as entitlement items for which the Federal Government is obligated by statute to provide appropriate matching.

II. General Discussion of the Bill

A. Adoption Assistance, Foster Care, and Child Welfare

(Title I of the Bill)

GENERAL APPROACH

Present law.—The title IV–A program, aid to families with dependent children (AFDC), is primarily designed to provide aid to needy children who are living in their own home—that is, a home maintained by a parent or close relative—but who have been deprived of ordinary parental support by reason of the death, incapacity, or absence from the home of at least one parent. (States at their option may also provide aid under this program to families in which the deprivation of support arises from the parent's unemployment.)

Since 1961, the AFDC program has also permitted Federal matching for aid provided to children who are not in their own home, but are in foster care. Such assistance is matched by the Federal Government only in the case of children who would be eligible for AFDC had they remained in their own home, but who have been removed from the home as a result of judicial determination and placed in foster care. Aid is available under this special AFDC foster care provision for such children in foster family homes and also in nonprofit private foster care institutions. As of January 1979, 104,108 children were being assisted through the AFDC foster care program. (See table 14 for State-by-State data.) The annual cost of this part of the AFDC program was $351 million in fiscal year 1977, of which $183 million represented the Federal share. (See table 1.)

According to HEW statistics, for the first 7 months of 1978, average monthly costs for AFDC foster care per child per month were $346. Broken out by type of placements, they averaged $259 in foster homes, and $708 in institutions. (Tables 2–7 show data for foster care programs by State.)

While the availability of Federal funding under the AFDC program for foster care has significantly enhanced the ability of the States to provide for the care of children who must be removed from their own homes, concern has been expressed over the need for increased efforts to move children out of foster care and into more permanent arrangements by reuniting them with their own families when this is feasible, or by placing them in adoptive homes.

There have also been criticisms of the quality of foster care which is being provided in many parts of the country under the AFDC foster care program. An HEW audit report based on field inspections between 1974 and 1976 found that in most of the 13 States covered by the report there were significant weaknesses in program management which had adverse effects on the types of care and services provided to foster children. According to the report, the auditors found (1) eleven instances involving problems with the licensing of foster care facilities, (2) two instances involving the mixing of foster children with

delinquent children, (3) eight instances involving problems with the preparation of plans of care, and (4) twelve instances involving the eligibility of children for the AFDC foster care program. They found at least 14 other types of conditions which were considered detrimental to the care of the children as well as the AFDC foster care program as a whole.

A 1977 study conducted for HEW, the National Study of Social Services to Children and Their Families, found that of all children in foster care, almost 400,000 were living in foster family homes, 12,000 were in public group homes, and 23,000 in private group homes. Almost 30,000 were in residential treatment centers and 43,000 were in public and private child care institutions. The National Study also found that two and one-half years was the median length of time all children in foster care had spent in care. It found that 38 percent of all children in foster care had been in placement for more than 2 years.

Most States (44 plus the District of Columbia) have adopted laws governing adoption programs, including the provision of subsidies to assist parents who adopt children with special needs. However, in some States, these laws have not yet been implemented. Several States, including California, Illinois, Maryland, Minnesota, and New York have been conducting programs for about the last 10 years. According to a study by the General Accounting Office, about 18,000 subsidized adoption placements have been made in the last 10 years. In fiscal year 1977, 41 States granted subsidies and nine of those States granted more than 100 new placement subsidies. Both maintenance and medical assistance for children with special needs are included in the laws of 43 of the 45 States that have them. One State provides only medical assistance, and one provides only maintenance assistance.

State activities in the areas of foster care and adoptions are not now closely monitored by the Federal Government. The child welfare services program under title IV–B of the Social Security Act provides a relatively small Federal contribution to the costs of State programs to protect and promote the welfare of children, including the provision of services to enable children to remain in their own homes, action to remove children from unsuitable homes and place them in foster care homes or institutions, and measures to place children in adoptive homes. Title IV–B authorizes annual appropriations of up to $266 million for child welfare services but the appropriation has never exceeded $56.5 million, or about 21 percent of the amount currently authorized. It is estimated by HEW that combined State and Federal expenditures reported under the title IV–B program will be about $800 million in fiscal year 1979, with State and local funds representing about 93 percent of that total amount. (See tables 9 and 10.) In addition, in fiscal year 1978, approximately $300 million in Federal title XX funds were spent for protective services provided to children and families.

Most of the expenditures reported by States under the title IV–B program are used to provide foster care, including income maintenance for children who are ineligible for foster care under the Aid to Families with Dependent Children (AFDC) program (title IV–A). According to HEW statistics, in 1979 about 3 percent of the total Federal, State, and local funding under IV–B was used for adoption services, 8 percent for day care, 73 percent for foster care, 8 percent for protective services, and the remainder for a variety of other child welfare services. (See table 10.)

Committee bill.—The committee believes that the authority in the law now to provide assistance to children in foster care has been of significant benefit to children over the years since it was originally enacted in 1961. However, the committee agrees that it would be appropriate and desirable at this time to modify the law in a way which will deemphasize the use of foster care and encourage greater efforts to place children in permanent homes. For this reason, the committee has made certain changes in the foster care provisions and has also adopted a new program of federally aided adoption assistance for children who would otherwise continue in foster care receiving benefits under the AFDC foster care provisions.

Under the committee bill, States would be required to establish goals as to the maximum number of children who will remain in foster care for in excess of 24 months. The bill would also make a distinction for funding purposes between adoption assistance and foster care payments to children eligible for AFDC. A ceiling would be placed on foster care payments beginning in fiscal year 1980 at 20 percent above the fiscal year 1978 expenditure level for foster care, with a 10-percent annual increase allowed through fiscal year 1984. (A higher ceiling would be provided for States with disproportionately small foster care programs in fiscal year 1978.) Federal matching would not be broadened to include cases without judicial determination, but would include care in public institutions caring for 25 or fewer children. The new adoption assistance program would be open ended. There would be no Federal matching for new adoption subsidy agreements for new foster care placements beginning in fiscal year 1985 so that the program could be reviewed by the Congress before the end of the trial period. Prior to that time, the Secretary of Health, Education and Welfare would be required to undertake and complete a study of foster care and adoption assistance under the new provisions.

A new section would be added to the child welfare services program specifically permitting expenditures for State tracking and information systems, individual case review systems, services to reunite families or place children in adoption, and procedures to protect the rights of natural parents, children and foster parents. The provision would allow the Congress to designate any new funding—over and above the current $56.5 million funding level, but within the overall $266 million now authorized—to be used specifically for this new section. This earmarking would be accomplished through the appropriations process and not as a part of the authorizing statute. State participation in this program would be optional. Funding for this program would be changed to a forward funding basis under which appropriations are made a year in advance of expenditures.

The Federal matching rate for the child welfare services program would be set at a flat 75 percent—unlike the range of from 33⅓ to 66⅔ percent under present law. In addition, any additional funds appropriated for child welfare services—above the present funding level of $56.5 million—could not be used for foster care maintenance payments.

ADOPTION ASSISTANCE

(Sections 101(a) and 102 of the Bill)

Present law.—Under present law there is no Federal matching for adoption subsidies under the program of aid to families with dependent

children. However, Federal funds for child welfare services may, among other things, be used for adoption subsidies. Forty-four States and jurisdictions now have adoption subsidy programs.

Although State adoption subsidy programs have in most cases been in existence for a relatively brief period, State officials involved in these programs are convinced of their value in finding permanent homes for hard-to-place children. The committee has received testimony on the importance of adoption subsidies in ending the current practice of leaving such children in foster care indefinitely.

Committee bill.—The committee bill would establish a new adoption assistance program (under a new part E of title IV of the Social Security Act) with Federal matching on the same basis as under the medicaid program. Under the adoption assistance program, a State would be responsible for determining which children in the State would be eligible for adoption assistance because of special needs which have discouraged their adoption. The State would have to find that any such child would have been receiving AFDC but for the child's removal from the home of his relatives; that the child cannot be returned to that home; and that, after making a reasonable effort consistent with the child's needs, the child has not been adopted without the offering of financial assistance. A search for a nonsubsidized adoptive family would not be required when such a search would be against the best interests of the child, for example, where the child had already established significant emotional ties as a foster child of the potential adoptive parents. Even in such cases, however, the State would have to determine that it could not reasonably expect to place the child in the absence of adoption assistance because of some specific factor or condition which makes the child hard to place. The determination could be based on such factors as a physical or emotional handicap, the need to place members of a sibling group with a single adoptive family, difficulty in placing children of certain ages or ethnic backgrounds, or similar factors or combinations of factors. Each State would be responsible for deciding which factors would ordinarily result in making it difficult to place certain children in adoptive homes. The committee expects, however, that the Department will sufficiently monitor this program to assure that *bona fide* determinations are being made on the basis of specific factors and that children are not being routinely classified as "hard-to-place."

If the State determines that adoption assistance is needed, it would be able to offer such assistance to parents who adopt the child, so long as their income does not exceed 125 percent of the median income of a family of four in the State, adjusted to reflect family size. The agency administering the program could make exceptions to the income limit where special circumstances in the family warrant adoption assistance (but not to exceed 10 percent of the State's adoption assistance cases). The amount of the adoption assistance would be agreed upon between the parents and the agency, could not exceed the foster care maintenance payment that would be paid if the child were in a foster family home, and could be readjusted by agreement of the parents and the local agency to reflect any changed circumstances. Adoption assistance payments would not be paid: (1) after the child has attained the age of 18; or (2) for any period when the family income rose above the specified limits. A child with a medical disability which existed at the time of the adoption would continue to be covered

under the medicaid program for treatment related to that medical disability. States would be permitted, if they wish, to make an adopted child with a preexisting medical condition eligible for treatment under medicaid for other medical conditions as well.

There would be no Federal matching for adoption subsidy agreements beginning in fiscal year 1985—though Federal matching for subsidies under agreements entered into before then would continue to be available. This would permit a review of the program by the Congress before the end of the 5-year trial period.

Where children are placed for adoption with assistance being provided under the new adoption assistance program, the nonrecurring costs involved in the adoption proceedings would be eligible for funding as child welfare services under title IV–B.

FOSTER CARE GRANTS

(Sections 101(a) and 102 of the Bill)

Present law.—Under present law open-ended Federal matching is provided for foster care payments under aid to families with dependent children if a child (1) meets State AFDC eligibility requirements, and (2) is removed from his home "as a result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child". AFDC foster care payments totalled $351 million in fiscal year 1977 with a Federal share of $183 million (52 percent). Table 1 shows these amounts by State.

Committee bill.—The committee believes that it would be appropriate in light of its desire to emphasize more permanent placement to convert the foster care program into a closed end authority. States have had over 17 years in which to utilize this program and develop its potentials. The committee provision accordingly would use the State's fiscal year 1978 expenditures under the program as a base allowing for further expansion under an indexing provision which would result in an increase of 20 percent in fiscal 1980 and 10 percent per year in each of the next 4 years—through 1984. (Under the committee bill, the ceiling would not be indexed further as of fiscal year 1985. However, before that year, Congress would have had an opportunity to review the appropriate level of funding inasmuch as additional legislation will be required to continue the program for placements made after the end of fiscal 1984.) The committee believes that this allows ample room for reasonable growth in this program over the next few years while measures designed to move children out of foster care into more permanent situations, that is, back into their own families or into adoptive homes, are being developed and implemented with the additional funding expected to be made available under the title IV–B child welfare services program. As a further incentive for emphasizing permanent placements, the funds available to each State within its new foster care ceiling could under the committee provision be used alternatively for child welfare services under title IV–B to the extent that the State does not need its full ceiling for foster care purposes. In addition, for any year an alternative foster care grant ceiling would be provided equal to each State's share of $100 million based on population under age 18 in each of the States. This would provide some additional room for program growth in those States which now have

disproportionately small foster care programs. Table 8 shows the distribution of the $100 million alternative amount.

In establishing a ceiling on foster care funding, the committee recognizes that certain expenditures are currently in dispute. The bill provides, accordingly, that the fiscal year 1978 base and subsequent year increments to that base—through 1984—will count the amounts in dispute until such time as the Secretary of HEW has reached a final determination as to whether or not those amounts are property chargeable as AFDC foster care expenditures. When such a final determination has been made, the State's foster care funding ceiling will be readjusted to conform to that determination. However, amounts payable to the State prior to the date of that determination will not be considered to be in excess of the ceiling as a result of the readjustment of the base.

In reviewing the need for legislation related to foster care, the committee has noted that the available statistical data on AFDC foster care indicates widely varying cost.

Data provided by the Department of Health, Education, and Welfare indicate that in the first 6 months of 1978 (January–June), the average cost of AFDC foster care per child varied from $764 a month in the highest paying State to $79 a month in the lowest. To a certain extent, the variations among the States reflect the varying degrees of use of institutional care, which is generally considerably more costly than care in a foster home. However, the committee also understands that there is at the present time general confusion about what can be called a foster care maintenance payment. The committee bill thus provides a specific definition to apply to foster care payments. The term is defined as payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, personal incidentals, liability insurance for the child, and reasonable travel to the child's home for visits. In the case of institutional care, the term includes the reasonable costs of administration and operation of the institution as are necessary to the provision of the items listed above.

The House bill would eliminate a requirement of present law under which Federal matching for AFDC foster care is available only in cases where the child's removal from his own home and placement in foster care has been accomplished through a judicial determination that such action is in the child's best interests. The committee amendment does not include this provision of the House bill but rather strengthens the existing law provision by requiring that the judicial finding also involve the question of whether efforts have been made to make it possible for the child to remain in (or return to) his own home. A major reason for the enactment of legislation dealing with these programs is the evidence that many foster care placements may be inappropriate and that this situation may exist at least in part because Federal law is now structured to provide stronger incentives for the use of foster care than for attempts to provide permanent placements. The committee feels that the elimination of the requirement for judicial determinations would be directly contrary to the purposes of the legislation in that it would move in the direction of providing additional incentives for States to choose foster care placements over the more difficult task of returning children to their own homes or placing them in adoptive homes. Moreover, such a change

would eliminate an important safeguard against inappropriate agency action. The committee is aware of allegations that the judicial determination requirement can become a mere *pro forma* exercise in paper shuffling to obtain Federal funding. While this could occur in some instances, the committee is unwilling to accept as a general proposition that the judiciaries of the States would so lightly treat a responsibility placed upon them by Federal statute for the protection of children. The committee notes that the existing law is written in such a way that emergency placements in foster care can be made and subsequently ratified by judicial determination without losing eligibility for AFDC matching after the determination has been made.

At the present time Federal funding of foster care maintenance payments for children is available for children placed in foster care homes and also for children placed in a nonprofit private child care institution. The committee bill would broaden the provision to allow for Federal funding of foster care maintenance payments for children in public as well as private facilities, but only if the public institution serves no more than 25 resident children. While the committee recognizes that this change in the law does somewhat expand the foster care authority of the law contrary to the committee's overall goal of deemphasizing foster care, the committee believes that such a change is important in order to encourage States to develop less intensive forms of institutional foster care. In other words, it is the intent of the committee that this authority be used by the States to make it possible to move children from large, highly institutionalized private institutions into smaller institutions which more nearly approximate the atmosphere of a home. Funding under this provision will not be available for children who are already in public institutions of this type, but only for those placed in such foster care after the enactment of the bill. Because the intent of this provision is to encourage the development and utilization of group home care, the committee expects that the administration will closely monitor claims for reimbursement under this authority to assure that payments are not made with respect to care in large institutions which have made superficial changes, such as the establishment of a "group home" wing within a larger institution. The committee intends that only institutions which are clearly and definitely separate entities serving 25 or fewer children will be covered by the provision. No Federal matching will be available under this provision for care provided in a detention facility, forestry camp, training school, or any other facility operated primarily for the detention of children who are determined to be delinquent.

The committee believes that the combination of an open-ended adoption assistance program and a closed-end foster care program represents an important restructuring of Federal incentives toward permanent placement of children. At the same time, the committee recognizes that substantial progress in this direction cannot be achieved by Federal fiat but can come about only through concerted effort and commitment on the part of State and local governments which have primary responsibility for carrying out these programs. Nevertheless, the committee believes that an important first step which can be required is the establishment of goals as to the maximum

number of children who will be in foster care for an extended period of time. Accordingly, the bill would require each State to establish by law goals for each fiscal year starting with fiscal year 1983 as to the maximum number of children who at any time during that year will have been in foster care for over 24 months. Each State plan will be required to describe the steps which will be taken by the State to achieve those goals. These requirements should help focus attention on the problem while at the same time providing a yardstick against which progress can be measured and a realistic assessment of what can be accomplished in these areas.

As indicated above, the committee bill provides for both the adoption assistance and foster care programs to terminate (insofar as new placements are concerned) on October 1, 1984. This provision assures that legislation in these areas will be considered before that date. The bill includes a requirement that the Secretary of Health, Education, and Welfare undertake a study of how these programs operate and report back to the Congress by October 1, 1983 with his findings and recommendations.

CHILD WELFARE SERVICES (TITLE IV–B)

(Sections 101(b) and 103 of the Bill)

Present law.—The child welfare services program under title IV–B of the Social Security Act provides a relatively small Federal contribution to the costs of State programs to protect and promote the welfare of children including the provision of services to enable children to remain in their own homes, action to remove children from unsuitable homes and place them in foster care homes or institutions, and measures to place children in adoptive homes. Title IV–B authorizes annual appropriations of up to $266 million for child welfare services but the appropriation has never exceeded $56.5 million. Total costs of operating these programs actually amounted to approximately $800 million in fiscal year 1977. The various categories of expenditures are shown in table 10.

Committee bill.—The committee bill would retain the provision of present law which authorizes an appropriation of $266 million annually for child welfare services, but would increase the Federal matching rate for the program to a flat 75 percent—unlike the range of from 33⅓ to 66⅔ percent under present law. So that additional Federal funds which the committee recommends be appropriated in future years are not simply used to replace State funds for foster care to children not eligible for AFDC, the committee bill provides that any additional funds appropriated for child welfare services—above the present funding level of $56.5 million—may not be used for foster care maintenance payments. Foster care maintenance payments above that level could, however, be used toward meeting the 25-percent non-Federal share of the program.

The committee believes that, by limiting the use of child welfare funds for foster care to the existing level of funding, the concern that new Federal funds will not result in new services to children will be

substantially allayed. It expects that appropriations levels will be increased in future years up to the full existing authorization levels with full confidence that the States will use the money in ways which best serve the needs of children. At the same time, the committee recognizes that concerns have been expressed over the need for increased accountability in the care of children who suffer from various forms of neglect. For this reason, the committee would retain the basic nature of the child welfare services program as one which is subject to annual review through the appropriations process. In addition, the committee would enable the administration to request that any new funds for the program be earmarked for use in accord with the procedures which the administration has proposed as a way to increase accountability in the program.

To enable States to plan for this program in an atmosphere of certainty as to the funding that will be available, the committee bill would shift the program to a forward funding basis. Under this approach, all appropriations made after the date of enactment of this legislation would become first available for expenditure in the fiscal year following the fiscal year to which the appropriation act applies. Thus, the $56.5 million already included in the 1980 Labor-HEW Appropriations Act would be available for 1980 expenditures. That amount, plus any increase, would have to be included in a 1980 supplemental and would become available for expenditure in fiscal 1981.

The committee bill would add a new section to the child welfare services part of the law specifically permitting expenditures for State tracking and information systems, individual case review systems, services to reunite families or place children in adoption, and procedures to protect the rights of natural parents, children and foster parents. This would allow the Congress to designate that any new funding—over and above the current $56.5 million funding level, but within the overall $266 million now authorized—be specifically for this new section. (This earmarking would be accomplished through the appropriations process and not as a part of the authorizing statute.) State participation in this part of the program would be optional.

In the first year for which funds are allotted to a State specifically for the new section those funds could be used:

1. For conducting and completing an inventory of all children who have been in foster care under the responsibility of the State for a period of 6 months preceding the inventory, including determining the appropriateness of and necessity for the current foster placement, whether the child can or should be returned to its parents or should be freed for adoption or legal guardianship and the services necessary to facilitate either the return of the child or the placement of the child for adoption.

2. To design and develop:

   (*a*) A statewide information system concerning children in foster care.

   (*b*) A case review system for each child in foster care under the supervision of the State. (Such a system—if funded under this new section—would have to include procedures for assuring placement in the least-restrictive setting and provision for an

annual or more frequent judicial or administrative review of: the appropriateness of the placement, compliance with the case plan, and prospects for returning the child home or placing him for adoption. Within 24 months after the initial placement, each child would have to receive a dispositional hearing by a court, tribal court, or court-appointed or approved administrative body to determine the future status of the child. The case review system would also have to provide for procedural safeguards concerning parental rights, the removal of a child from the home, changes in placement, and visitation rights.)

(c) A service program designed to help children remain with their families and where appropriate help children return to families from which they have been removed or be placed for adoption or a legal guardianship.

(In that first year only, administrative expenses incurred for conducting the inventory and for designing the information and case review systems—insofar as children receiving foster care under part E are involved—could be funded under that part without regard to the ceiling on foster care funding which would otherwise apply. This authority applies only to administrative costs which otherwise qualify for part E matching.)

When the inventory has been completed and the systems and programs have been designed and developed, funding appropriated for the new section could be used to operate the systems and programs described in item 2. A State which already has an inventory of children in foster care and has developed the specified systems and programs could immediately use any funds which may be appropriated under the new section.

An additional element of the committee bill would authorize the Secretary of Health, Education, and Welfare—to the extent he determines appropriate—to deal directly with recognized Indian governmental entities in making child welfare services grants under title IV–B.

The committee bill also requires States to provide statistical information on foster care and adoptions which would be published by the Secretary of HEW. Grants for child welfare services could be used to comply with the statistical reporting required by the bill.

The committee bill differs in a number of respects from the House provisions related to foster care, adoption assistance and child welfare services. The following pages compare present law, the committee bill, and the House bill.

II. CHILD WELFARE SERVICES—TITLE IV-B—Continued

Current Law	H.R. 3434 as reported by the Finance Committee	H.R. 3434, as passed by the House
4. Allotments to States		
Provides $70,000 to each State with remainder of amount appropriated to be distributed according to a formula which varies directly with the number of children under age 21 and inversely with the average per capita income.	Current law.	Current law.
5. Reallotment of Funds		
Permits reallotment of funds not needed by one State to other States which the Secretary determines have need for such funds to carry out their State plans and will be able to use such funds in the fiscal year. Reallotments are to take into consideration the population under age 21 of each State and the State per capita income.	Current law.	Repeals the present law provision for reallocation of unused funds.

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may not provide services, other than protective services, family planning services, and information and referral services to families with incomes above 115 percent of the State median income. For 1980, this ranges from a low of $16,830 for a family of four in Mississippi, to a high of $36,937 in Alaska. (See table 13.)

States use their title XX money in very different ways, depending on their own State-determined needs. On a national basis, the service for which the largest amount of money is being spent is child day care. HEW estimates for 1979 indicate that about 21 percent of all Federal social services funds will be spent for child day care. Homemaker/chore services are expected to account for slightly more than 12 percent of all funds in 1979, and education, training and employment services are estimated to account for an additional 10 percent. Protective services and child foster care services together will account for another 16 percent of total spending. (See tables 14 and 15.)

DETERMINATION OF AMOUNT ALLOCATED TO STATES

(Section 201 of the Bill)

Present law.—As indicated above the present permanent ceiling on title XX Federal funding of social services was established in 1972 at a level of $2.5 billion. Legislation enacted in 1976 provided for a temporary increase in the limit on Federal funding under the title XX program. The amount made available was $40 million for the calendar quarter July–September 1976, and $200 million for fiscal year 1977. The additional funding was allocated among the States in the same way as the permanent $2.5 billion limit, i.e., on a population basis. The new funds were made available to the States on a 100 percent Federal funding basis and could not exceed the amount of State expenditures for child care. Subsequent legislation extended these temporary funding provisions for fiscal years 1978 and 1979, thus providing the States with an additional $200 million in title XX funds for those years. In addition, the 95th Congress temporarily raised the basic $2.5 billion ceiling on social services spending to $2.7 billion for social services, resulting in an overall ceiling of $2.9 billion including the special funding for child care. Under present law, the annual amount of Federal funding for title XX services reverted to $2.5 billion (the amount provided under the permanent ceiling) as of October 1, 1979. (See table 11 for State-by-State allocations for fiscal year 1979.)

Committee bill.—When the $2.5 billion ceiling was originally established in 1972, it was adequate to allow room for significant program growth in most States. Even then, however, there were some States already at their limits under the ceiling, and since then all States have reached their maximum funding level. As a result, there is no additional room for meeting additional services needs within the present

ceiling. While States may be able to reevaluate their title XX programs to effect economies and to eliminate some items of low priority, such savings would tend to be offset by the impact of inflation on other, high priority services.

It was the judgment of the committee in making its budgetary recommendations earlier in the year, that this program should at least be maintained at its fiscal 1979 level of $2.9 billion. It is the understanding of the committee that the budgetary goals for fiscal year 1980 incorporated in the First Concurrent Budget Resolution were consistent with a continuation of the $2.9 billion title XX level. (In social services as in several other areas of the budget, the House interpretation of the First Budget Resolution differed substantially from the Senate interpretation. The House interpretation held that the budgetary goals in the social services function would accommodate a title XX funding level of $3.1 billion and that is the level incorporated in the House version of H.R. 3434. In the Senate, however, the First Budget Resolution was interpreted by the Senate Budget Conferees as allowing room in that budget function for no more than a $2.9 billion title XX program funding level.)

The Senate has now passed a Second Budget Resolution for fiscal year 1980 with budgetary totals which are inconsistent with a ceiling for this program in excess of $2.7 billion. This, of course, represents the Committee's understanding as to the assumption for this program underlying the Budget Resolution totals. The Committee recognizes that the Budget Resolution is binding only as to its totals and not as to specific legislative assumptions which may have been understood to underlie those totals. Nevertheless, the overall budgetary totals in the second resolution, as passed by the Senate, would require even more substantial reductions in other programs under Finance Committee jurisdiction. Consequently, the committee believes that it cannot, in the light of the Senate Budget Resolution, recommend a fiscal 1980 title XX level in excess of $2.7 billion at this time. The Committee stands ready, however, to reassess this level after Congress completes action on the Second Budget Resolution.

While the Committee, for the reasons stated above, cannot recommend title XX levels in excess of $2.7 billion for fiscal year 1980, the Committee is concerned about the impact of inflation on the programs operated under that title and particularly so in view of the fact that the permanent ceiling has been reached by all States. For this reason, the committee believes that is it appropriate at this time to consider a moderate amount of indexing for this program over the next several years, in order both to provide some assistance to States in meeting the impact of inflation on high priority service programs and to provide States with advance knowledge of the amount of funding they can expect for those programs. Under the committee bill, therefore, the title XX ceiling will be indexed to inflation in the following manner: for fiscal year 1980 and each subsequent year, the ceiling will be modified by the percentage change (increase or decrease) in the consumer

price index during the preceding year. This percentage change will be applied to the permanent $2.5 billion base and will be added to the prior year ceiling (or subtracted from it in the event of a decrease). (For fiscal year 1980 the "prior year ceiling" will be the permanent ceiling of $2.5 billion rather than the temporary $2.9 billion.) In calculating these cost of living modifications, any increase (or decrease) which is not an exact multiple of $100 million will be rounded downward to the next lower multiple of $100 million.

The period over which the change in the cost of living will be measured under the bill is the one-year period ending 6 months before the start of the fiscal year in question. This is the same indexing period used for purposes of determining cost of living increases under the social security program. In order to assure that this indexing formula will not create an unanticipated drain on the Federal Treasury, the bill specifies that the percentage increase in any year cannot exceed the inflation rate assumed by the Senate Budget Committee in developing the second concurrent budget resolution for fiscal year 1980, as shown on page 25 of Senate Report 96–311. (In the case of fiscal years after 1984, the percentage would be limited to the Budget Committee's forecasted inflation rate of 7.4 percent for 1984.)

Under current economic forecasts of the Administration and the Congressional Budget Office, the indexing formula in the committee bill will result in a title XX ceiling level of $2.7 billion in fiscal year 1980, $2.9 billion in fiscal year 1981, $3.10 billion in fiscal year 1982, $3.2 billion in fiscal year 1983, and $3.2 billion in fiscal year 1984 and $3.3 billion in fiscal year 1985. In order to assure a reevaluation of the appropriateness and the effectiveness of the indexing provisions, the bill provides that further increases under the indexing provisions will not take place after the ceiling reaches a level of $3.3 billion in the absence of subsequent legislation to extend those provisions.

SPECIAL ALLOCATION FOR CHILD CARE SERVICES

(Section 202 of the Bill)

Present law.—Among other provisions in the 1974 social services amendments was a formal incorporation into the title XX program of certain standards for child care services funded under the title XX program. The child care standards were a modified version of the Federal Interagency Day Care Requirements which were published in 1968. The Federal Interagency Requirements had previously been applicable to child care under the social service program but compliance with them had not been monitored.

The standards for child care were to have become effective beginning October 1, 1975. However, because the imposition of the standards relating to staffing would have increased the cost of operation of the program and because of disagreement as to the appropriateness of the

standards, Congress enacted legislation postponing their implementation on a mandatory basis, pending a study of their appropriateness which the law required be conducted by the Department of Health, Education, and Welfare. The findings of that study were published in July 1978 and the Department is currently holding hearings on proposed regulations which it expects to issue in final form before the end of calendar year 1979.

Pending resolution of the standards issued the 1976 legislation provided for an increased level of title XX funding to enable States to improve their child care programs in such ways as they found most appropriate. On a full-year basis the additional funding provided for in that legislation totaled $200 million which was available to the States without the usual 25 percent non-Federal matching requirement. This funding could be used only for services related to the provision of child care. (However, States were free to use this amount to continue existing child care programs as well as to improve those programs or provide new child care services.) This special $200 million allocation for child care has subsequently been continued through fiscal year 1979 (as a part of the overall $2.9 billion ceiling).

Committee bill.—The Committee believes it is appropriate, at least for the time being, to continue this special child care allocation that has been in existence for the past few years. Accordingly the Committee bill provides that, in fiscal 1980 and 1981, that $200 million of the overall title XX ceiling (as determined under the preceding section) will be considered as a child care allocation available without non-Federal matching requirement.

TEMPORARY LIMITATION ON FUNDS FOR TRAINING

(Section 203 of the Bill)

Present law.—In addition to providing for the funding of social services, title XX also provides for funding "personnel training and retraining directly related to the provision of those services (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions)." Federal funding for training costs, like other Federal funding under title XX, is on a 75 percent Federal, 25 percent non-Federal basis. Training funding, however, is not governed by the overall title XX funding ceiling but is completely open-ended. The President's budget for fiscal year 1980, citing recent rapid growth in expenditures for training, proposed legislation to place a limit on Federal funding for training for each State equal to 3 percent of its title XX allocation. This limit would have been phased in over a 3-year period. Table 17 shows the most recent estimates of expected Federal costs of title XX in fiscal 1979.

Committee bill.—The committee amendment would establish a limit, for one year (fiscal year 1980), on the amount of Federal matching funds available to the States for training. Notwithstanding any other provision of law, the limit for each State would be equal to 4 percent

of that State's 1980 allotment under the title XX funding ceiling or the actual amount spent by the State in fiscal year 1979, whichever is higher.

In establishing this fiscal year 1980 limit, the committee notes that it is changing the open-ended nature of the funding for this program but is not changing the entitlement nature of the program. As with other Social Security Act matching grant programs, States have a right to expect that the Federal Government will live up to its statutory commitment to match qualified expenditures.

The Committee expects that the Department of Health, Education, and Welfare will undertake a thorough review of how title XX training funds are being used by the States, and the effectiveness of current State training programs in improving the delivery of title XX services. The Committee intends to develop a more permanent resolution of this matter and will need this information in its consideration of legislation relating to the use of training funds in years after 1980. Because the committee intends to review this issue in the near future, it did not include the provision of the House bill requiring an HEW-approved State plan starting in 1981.

USE OF RESTRICTED PRIVATE FUNDS FOR TRAINING PROGRAMS

(Section 204 of the Bill)

Present law.—Under present law, donated private funds used for title XX services must be donated to the State without restrictions (1) as to use, other than restrictions as to the type of donor who is not a sponsor or operator of a program to provide these services, and (2) as to the geographic area in which the services are to be provided.

Committee bill.—The committee bill would permit the acceptance by the State of restricted private matching funds for social services training for fiscal year 1980. Funds used as the non-Federal match under authority of this provision could not be used to pay for training provided by for-profit facilities. The committee believes that allowing for the use of restricted private matching funds will encourage private organizations and foundations to contribute to the strengthening of State training programs, thereby improving the State's capacity to deliver services to those who need them. Since this is an expansion of existing authority in this area, the Department of Health, Education, and Welfare should monitor the use made of this authority. However, the committee intends that such monitoring be carried out in a careful and reasonable manner that will not result in discouraging those who would wish to make use of the provision. The committee believes that the provisions of section 204 placing a ceiling on the previously open-ended nature of the title XX training provisions largely remove whatever objections might otherwise be raised against permitting the use of donated funds on a restricted basis. However, since that section is effective only for one year pending further study of the issue by the committee, a similar one-year limitation has been placed on this provision. The committee expects, however, that it would act to extend this provision at the time that it recommends a further resolution of the ceiling issue.

EMERGENCY SHELTER

(Section 205 of the bill)

Present law.—Under present law, States may use funds to provide emergency shelter for children as a protective service for up to 30 days. HEW regulations provide that this service is limited to 30 days within any 6-month period. Every State now provides for emergency shelter services for children as part of the State plan.

Committee bill.—The bill would allow States to provide shelter care for adults who are in need of this service as well as for children. Under the committee bill, emergency shelter could be provided, for up to 30 days in any 6-month period, as a protective service to an adult in danger of physical or mental injury, neglect, maltreatment, or exploitation. Many adults faced with emergency situations arising from domestic violence, accident, or other cause may be temporarily unable to provide for themselves and, in particular, may face an urgent and immediate need for short-term shelter. Moreover, the committee has been told by the administration that cases involving the need for emergency shelter for a child will often also involve a similar need for a parent of the child. Under the committee provision, States would be given the flexibility to deal with situations of this type.

MULTIYEAR PLAN; CHOICE OF FISCAL YEAR

(Section 206 of the bill)

Present law.—Title XX of the Social Security Act provides great flexibility to the States in the design and operation of social services programs to meet the needs of their citizens. Because of the diversity of needs and services programs, the statute requires States to undertake periodic reassessment of these programs through the development each year of a comprehensive social services plan which will govern the operations and scope of the program within the State. States have the option under present law of using either the Federal fiscal year or the fiscal year used by the State government as the social services program year to which the annual State plan will apply.

Committee bill.—The committee believes that it would be appropriate at this time to provide a degree of additional flexibility to the States in developing their social services plans. Accordingly, the committee amendment would eliminate the requirement that such plans

be limited to only a single year and would allow States the option of using a 1-, 2-, or 3-year services program period. The committee feels that adequate levels of reassessment can be achieved within these longer periods and that States will be able to conserve some of resources now devoted to the annual planning process. However, if States elect a program period of longer than one year, the State agency will be required to publish and make generally available such information concerning the program at such times as the Secretary may by regulation require. The committee amendment also allows States an additional option as to the fiscal year with which the services program periods must coincide. Under the amendment, States would be permitted the option of using a services program period which coincides with the fiscal year used by the local units of government within the State. This change is necessary in those States where local governments have a major role in the operations of the title XX program and utilize a fiscal year which differs from both the State and Federal fiscal years.

SOCIAL SERVICES FUNDING FOR TERRITORIES

(Section 207 of the Bill)

Present law.—Puerto Rico, Guam, and the Virgin Islands do not participate in the title XX social services program on the same basis as the States. Instead, they may receive an allotment for social services only from the amount that the States and the District of Columbia certify, after the beginning of the fiscal year, that they will not use out of their share of the $2.5 billion in Federal funding under the title XX program. The law specifies that in no case can the allotment exceed $15 million for Puerto Rico and $500,000 each for Guam and the Virgin Islands. Because under present provisions of law these jurisdictions do not know in advance of the program year whether they will have any title XX funds available to them, or the magnitude of those funds, they have had difficulty in making the most effective use of the funds that have become available.

Committee bill.—The committee bill would amend present law by providing that, beginning in fiscal year 1980, a separate title XX entitlement amount would be established, as follows: Puerto Rico, $15 million; Guam and the Virgin Islands, $500,000; and the Northern Marianas, $100,000. This provision will allow these jurisdictions to plan in advance how their social services funds should be spent in order to provide for the effective delivery of such services.

TABLE 17.—TITLE XX TRAINING FUNDS—1979 ESTIMATED FUNDING AND IMPACT OF 4-PERCENT LIMIT—Continued

[In thousands of dollars]

State	Estimated 1979 Federal funding	4 percent of $2.7 billion allocation
Ohio	805	5,342
Oklahoma	394	1,403
Oregon	1,414	1,186
Pennsylvania	3,896	5,883
Rhode Island	555	466
South Carolina	948	1,435
South Dakota	340	343
Tennessee	1,546	2,146
Texas	9,625	6,405
Utah	1,498	633
Vermont	505	241
Virginia	596	2,563
Washington	2,011	1,826
West Virginia	2,428	928
Wisconsin	1,686	2,323
Wyoming	177	202

Source: Based on data from Department of Health, Education, and Welfare, representing estimates received from States, not including late claims.

PERMANENT EXTENSION OF PROVISIONS RELATING TO CHILD SUPPORT ENFORCEMENT, CHILD DAY CARE SERVICES, AND SERVICES FOR ALCOHOLICS AND DRUG ADDICTS

(Section 208 of the Bill)

For the past few years, certain aspects of the social services and child support programs have been operated under authority of provisions which were originally enacted on a temporary basis and had been extended from time to time. During the last Congress there appeared to be general agreement on the desirability of extending these provisions on a permanent basis. However, for reasons unrelated to these provisions, the legislation to accomplish that objective did not reach final enactment prior to the adjournment of the Congress. Consequently, authority to fund these programs lapsed as of October 1, 1978. Because of the importance of these provisions and the fact that States had continued to provide these services in the expectation that the authority for them would be restored, the Senate acted early in this Congress to pass legislation reinstating the funding for these programs on a permanent basis and retroactive to October 1, 1978. This legislation was

agreed to as an amendment to the bill H.R. 3091. Up to now, however, the House of Representatives has been unwilling to agree to these amendments to that bill. The committee has incorporated provisions identical in substance to the Senate-passed amendment to H.R. 3091 in section 208 of the committee bill as described below.

1. CONTINUED FEDERAL MATCHING FOR CHILD SUPPORT SERVICES FOR NONWELFARE FAMILIES

Present Law.—The child support and establishment of paternity program, enacted at the end of the 94th Congress as title IV–D of the Social Security Act, mandates aggressive administration at both the Federal and State levels with various incentives for compliance and with penalties for noncompliance. The program includes child support enforcement services for both welfare and nonwelfare families. The child support enforcement program leaves basic responsibility for child support and establishment of paternity to the States, but provides for an active role on the part of the Federal Government in monitoring and evaluating State child support enforcement programs, in providing technical assistance, and, in certain instances, in undertaking to give direct assistance to the States in locating absent parents and obtaining support payments from them.

To assist and oversee the operation of State child support programs, the Department of Health, Education, and Welfare is required to set up a separate organizational unit under the direct control of a person designated by and reporting to the Secretary. Since the March 1977 reorganization of HEW the Commissioner of Social Security is the Director of the Office of Child Support Enforcement. The Office of Child Support Enforcement reviews and approves State child support enforcement plans, evaluates and audits the implementation of the program in each State, and provides technical assistance to the States. Recently the office established a National Child Support Enforcement Reference Center as a central location for the identification, collection and dissemination of useful information from State and local programs. In addition, it has created a National Institute for Child Support Enforcement to provide training and technical assistance to persons working in the field of child support enforcement.

HEW regional child support staff, under the regional child support representative, are responsible solely for title IV–D and report directly to the Office of Child Support Enforcement. The manner in which the Department of Health, Education, and Welfare has complied with the requirement of a separate organizational unit for child support enforcement is in keeping with the spirit and intent of present law and is analogous to the organizational structure for child support enforcement in many States—particularly States with highly cost-effective programs such as Michigan, Massachusetts, Washington, and Iowa.

The legislation creating the child support program requires each State to have a program of child support collection and paternity establishment services for both AFDC and non-AFDC families administered by a single and separate organizational unit within the State under a separate State plan for child support administered separately from other State plans.

The States administer the child support program through separate child support agencies, popularly referred to as IV–D agencies. In

most States the program is administered directly by the State agency, in a few States it is administered by local agencies under State supervision and in two States it is administered by the State in some jurisdictions and by local agencies in others.

The statute provides Federal matching of 75 percent for services to AFDC families and for parent locator services for families not receiving welfare benefits on a permanent basis. Matching for other services to non-AFDC families was originally provided for one year, but has been extended through fiscal year 1978.

The act also provides for a parent locator service within the Department of HEW's separate child support enforcement unit. The act further requires that a mother, as a condition for welfare, assign her right to support payments to the State and cooperate in identifying and locating the father and securing support payments except when cooperation is determined not to be in the best interest of the child.

The legislation requires that State child support plans provide for entering into cooperative arrangements with appropriate courts and law enforcement officials to assist the child support agency in administering the program. The law specifically requires the entering into of financial arrangements with such courts and officials in order to assure optimum results under the child support program and with respect to any other matters of common concern to the courts and the child support agency.

In the first 44 months of the child support program (August 1975 through March 31, 1979), States have reported total collections of over $3.2 billion, of which $1.47 billion was for AFDC families and $1.76 billion for families not on welfare, at a total cost of $0.95 billion or 30 cents per dollar collected (see table 18).

The increasing success of the child support enforcement program is reflected not just in the amounts of child support collected, but also in other program results. In those States reporting the information:

> In the first 44 months of the child support enforcement program, 1,439,000 absent parents were located; there were 870,000 support obligations established; and paternity was established by the courts for 293,000 children (see table 19).

It was the expectation of the committee that the successful implementation of the child support program would result in a decrease in the aid to families with dependent children (AFDC) rolls. Nonwelfare families would receive increased child support collections, and would therefore not be forced to turn to the AFDC program for assistance. In addition, families already on the rolls would be enabled to become self-supporting and end their welfare dependency. In fact, the number of AFDC recipients in July 1979, the latest month for which statistics are available, was the lowest since July 1971. The current number of recipients, 10.2 million, is a decrease of over 1.2 million from March 1976. The child support program may well have been a factor in these decreases. There is no way of knowing how much has been saved in welfare costs in those cases where the family receives child support and need not apply for welfare payments.

Committee bill.—The committee believes that the requirement that every State have a program of child support collection and paternity establishment services for families that are not receiving welfare is an

essential component of the child support program. The purpose of the requirement is to assure that abandoned families with children have access to child support services before they are forced to apply for welfare. It is the opinion of the committee, supported by the statements of many State child support administrators, that access to these services often means the difference between a family's reliance on welfare support and being supported by a legally responsible parent. Most of the families being served are marginally eligible for AFDC, and without child support services are likely to end up on the welfare rolls.

The committee believes that most of the existing programs of required services for non-AFDC families will flounder if Federal financing for the services is not fully restored. It also believes that States will not be willing to develop and expand the programs unless they are convinced that Federal financing will be continued without interruption. In addition, it seems reasonable and fair to assist in the financing of a State program which is mandated by Federal law. The committee notes in particular that States which do not have an effective program for non-AFDC families are subject to a penalty provision which requires a reduction in Federal matching for AFDC of 5 percent if a State is found as the result of a Federal audit to have failed to have an effective child support program. For these reasons, the committee amendment would provide for Federal matching for services to non-AFDC families on a permanent basis effective October 1, 1978. This provision has previously been approved by the Senate as an amendment to the bill H.R. 3091.

TABLE 18.—TOTAL AFDC AND NON-AFDC COLLECTIONS AND TOTAL EXPENDITURES, BY STATE—AUG. 1, 1975 THROUGH MAR. 31, 1979

	Total AFDC collections	Total Non-AFDC collections	Total collections	Total expenditures
Total	$1,465,058,083	$1,762,544,699	$3,227,602,782	$953,750,806
Alabama	4,956,091	74,258	5,030,349	10,128,665
Alaska	720,135	10,750,871	11,471,006	3,408,588
Arizona	1,206,785	3,936,762	5,143,547	5,263,217
Arkansas	3,469,253	1,372,084	4,841,337	4,594,962
California	223,983,200	243,650,688	467,633,888	227,854,100
Colorado	10,522,974	3,483,708	14,006,682	9,834,045
Connecticut	31,649,780	38,405,617	70,055,397	13,050,841
Delaware	4,135,103	16,744,394	20,879,497	2,405,039
District of Columbia	2,165,452	167,151	2,332,603	3,510,339
Florida	10,738,136	2,376,219	13,114,355	13,479,965
Georgia	12,841,648	1,797,989	14,639,637	6,535,821
Hawaii	4,034,988	828,161	4,863,149	2,818,852
Idaho	5,524,287	834,760	6,359,047	2,726,633
Illinois	28,267,968	1,024,394	29,292,362	16,096,684
Indiana	19,716,753	1,185,882	20,902,635	8,482,216

Committee bill.—Effective for taxable years beginning after December 31, 1978, the Committee amendment would permit the tax credit and related title XX grant provisions to be applied to part-time as well as full-time employment by welfare recipients in child care jobs.

CHANGES RELATED TO PUBLIC LAW 95–600

Present law.—The 1978 tax reduction act (Public Law 95–600) made several significant changes in the tax credit provisions for hiring welfare recipients. Under prior law, the tax credit for hiring welfare recipients in child care jobs was limited to 20 percent of the first $5,000 of wages and was available only through September 30, 1978. Effective January 1, 1979, the new law treats child care jobs in the same manner as other employment for purposes of the tax credit. The credit is made permanent and applies to the first $6,000 of wages (at a 50 percent rate in the first year and a 25 percent rate in the second year).

Committee bill.—The committee amendment contains several provisions related to the changes made by Public Law 95–600:

1. The title XX grant provisions would be conformed to the $6,000 maximum wages creditable for the tax provision. (That is, grants up to $5,000 per eligible employee could be made for profit-making child care facilities and up to $6,000 for public and non-profit facilities).
2. The former tax credit provisions for child care jobs are reinstated for the period October 1, 1978 to December 31, 1978. (After that date, the new provisions of Public Law 95–600 are effective under existing law.)
3. A number of technical amendments are made to perfect the transition provisions in Public Law 95–600 and to rectify certain clerical errors in that statute.

3. ADDICTS AND ALCOHOLICS

Present law.—Since the enactment of title XX the number of States reporting the provision of services to alcohol and drug abusers has significantly increased. In 1976, 36 States included services to these individuals in their State plans. In 1978, a total of 45 States indicated that they would target services for alcoholics and drug abusers. In Public Law 94–120 the Congress enacted several temporary amendments to title XX to strengthen the services which States could provide to alcoholics and drug addicts. These provisions, originally enacted for 1 year, were later twice extended and expired September 30, 1978.

Committee bill.—The committee bill would reinstate and make permanent, effective October 1, 1978, the temporary provisions of law relating to the use of title XX funds for certain services to alcoholics and drug addicts. Title XX funds ordinarily may only be used to provide health services if the services are an integral, but subordinate, part of a social service. The law provides also that funds may not be used for services to persons in medical institutions. The committee amendment would make permanent those expired provisions of law which permitted consideration of the entire rehabilitative process in determining whether medical services provided to addicts and alcoholics are an integral but subordinate part of a social service. Also

made permanent would be provisions allowing funding for up to 7 days of detoxification services provided to alcoholics and drug addicts in medical institutions, and provisions applying the privacy protections of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. This amendment has previously been approved by the Senate as an amendment to H.R. 3091.

PROVISIONS OF THE HOUSE BILL NOT INCLUDED IN THE COMMITTEE AMENDMENT

In addition to other matters discussed above the following provisions were in the House-passed version of H.R. 3434 but have not been included in the committee amendment.

Consultation with local officials.—Under Section 105 of the House bill, States would be required, prior to publication of their proposed title XX plan, to give public notice of intent to consult with the chief elected officials of the political subdivisions of their State and provide such officials the opportunity to present their views. A summary of the principal views of the local officials would have to be included in the plan.

Plan requirement for distribution of funds within a State.—Present law requires each State to include in its plan a description of the geographic areas in which services are to be provided and the nature and amount of the services to be provided in each area. Section 107 of the House bill would add a requirement that the State specify those areas which it has determined are in special need of services, and that it describe the criteria used to determine the nature and amount of services to be provided in each area.

Statement of purpose.—Current law provides that the purpose of title XX is to encourage States to furnish services directed at 5 goals, which are stated in the law. Section 110 of the House bill would add language stating that it is the purpose of title XX to meet social services needs which are not otherwise being met, particularly in areas of the State with special needs, in order to make available a comprehensive range of services to eligible beneficiaries.

Committee bill.—The committee bill does not include these provisions. The title XX program covers a wide range of services meeting the varied needs of several diverse segments of the population. The program was intentionally designed with a view towards providing each State with great flexibility in designing, developing, and operating its social services plan. The committee is not convinced that the addition of several new Federal requirements is consistent with the fundamental purposes of the title XX program. Moreover, in the light of the budgetary situation and the fact that all States have reached their Federal funding ceiling levels, the committee questions whether States should be required to divert program resources to meeting new Federal procedural mandates. The committee is also concerned over the possibility that individuals dissatisfied with the level of resources devoted to particular programs might view these new Federal requirements as an invitation to litigation.

Using the same example but assuming higher earnings, the family would remain eligible for AFDC up to a total earnings level of $770 per month under the committee bill as compared with $870 under existing law.

INCENTIVE TO REPORT INCOME UNDER AFDC PROGRAMS

(Section 302 of the Bill)

Present law.—Quality Control reviews show that a large percentage of the payment errors made in the AFDC program relate to earned income and the failure of the recipient to report the correct amount of any changes in amount earned. Of all cases involving error, the major concentration was in earned income—over 20 percent. A few States require that all income be reported on a monthly basis, as a condition of eligibility. Most States do not do this. When they learn that a recipient had unreported earned income in prior months, they give him the benefit of all the earned income disregards provided in law in calculating the amount of the overpayment. Thus, if a recipient is negligent in reporting his earnings even over a long period of time there is no penalty involved.

Committee bill.—The committee believes that there should be an incentive in the law for recipients with earnings to report their income on a prompt and complete basis. The committee amendment would accomplish this by providing that there would be no disregard of any earned income which the recipient has not reported to the State agency. This provision should have a significant impact in reducing errors and problems of overpayments relating to earned income.

INCOME OF STEPPARENTS

(Section 303 of the Bill)

Present law.—Under present law a stepparent's income may not be considered in calculating the AFDC benefit due a stepchild unless the stepparent is legally responsible for stepchildren under State law. According to the Department of Health, Education, and Welfare, there are only two States which have such laws. Thus, in all other States, families which include a stepparent may receive AFDC regardless of the amount of the stepparent's income. Income is counted only in those cases in which the State agency has been informed that the stepparent is actually making a contribution toward the child's needs.

Committee bill.—The committee believes that a stepparent should be considered part of the family unit for purposes of the AFDC program. It recognizes, however, that the stepparent may have other obligations and needs which should be taken into consideration in determining the amount of income which could reasonably be expected to be available to his stepchildren. The committee bill therefore requires that the stepparent's income be considered in determining a stepchild's benefit, but only after specific items have been taken into account.

Under the committee amendment, States would be required to take into account that part of the unearned income plus 80 percent of the earned income of a stepparent which exceeds the sum of: (1) the State

standard of need for a family of the same composition as the stepparent and his dependents who are not receiving welfare (that is, those members of the household whom he claims as Federal personal income tax dependents but who are not in the AFDC recipient group); (2) amounts paid by him to dependents living elsewhere which are taken into account for Federal personal income tax purposes; and (3) alimony or child support payments made by him to persons not living in the household.

The following example shows how this provision would operate.

Family composition: 4 persons: a man and wife each of whom has one child by a previous marriage (man pays alimony to former spouse).

State AFDC need standard for 2 person family: $200.

Income of wife and her child: None

Income of husband and his child:

Monthly earnings	$300
Unearned income	50
Total	350

Present law

AFDC payment to the wife and her child is $200 since the income of the stepfather is not counted.

Committee bill

80 percent of the husband's earnings; plus	$240
All of his unearned income	50
Total	290
Less alimony payment to his former spouse	45
	245
Less hypothetical AFDC need standard for the husband and his child	200
Remainder is applied to reduce AFDC payment to the wife and her child from $200 to $155	45

PRORATING OF SHELTER ALLOWANCE WHEN AFDC HOUSEHOLD INCLUDES INELIGIBLE RELATIVES

(Section 304 of the Bill)

Present law.—Under present law, an AFDC household may include one or more members who are not actually considered a part of the AFDC eligibility group. For example, an uncle living with the family could be excluded from the AFDC computations since he is not legally responsible for the support of the other members of the household. In such a case, his needs would not be counted in determining the size of the grant and his income would not be used to reduce the amount payable. AFDC studies have shown that a substantial proportion of all AFDC households include such ineligible relatives.

Committee bill.—States would be permitted, in computing the shelter cost component of the AFDC grant, to assume in effect that such an ineligible relative in the AFDC household bears his proportionate

share of the shelter expenses. This would be computed as follows: instead of applying the shelter allowance applicable to the actual AFDC eligibility group the State would use the larger shelter allowance that would apply to a group including the AFDC unit and the ineligible relatives. That larger allowance, however, would be reduced on a prorata basis in accordance with the ratio of the number of AFDC eligibles to the total number of AFDC eligibles plus ineligible relatives. For example, if the household included 4 AFDC eligibles plus two ineligible relatives and the shelter allowance for a 6-person family was $60, the amount actually payable for shelter would be $40 (four-sixths of the full allowance). The provision would apply only if the overall household income exceeded the State's AFDC standard of need for a household of that size.

SERVICES FOR DISABLED CHILDREN

(Section 305 of the Bill)

Present law.—As part of the supplemental security income program (SSI), the Social Security Administration is required to refer blind and disabled children who are receiving benefits to an appropriate State agency for counseling, medical, rehabilitative and social services. The State agency to be used for referral is either the agency administering the crippled children's program, or another agency designated by the Governor if he finds that such agency could administer the program of services more effectively.

The agency responsible for administering the State program must operate under a State plan which includes provision for counseling of disabled children and their families, the establishment of individual service plans for children under 16, monitoring to assure adherence to the plans, and provision of services to children under age 7 and to children who have never been in school and require preparation to take advantage of public educational services.

A total of $30 million was made available for fiscal years 1977, 1978 and 1979. The funds are allocated on the basis of the relative number of children age 6 and under in each State. The law provides that up to 10 percent of the State's funds may be used for counseling, referral and monitoring which is provided under the State plan for children up to age 16. The remainder of the funding is available for services to disabled children under age 7 and those who have never been in school.

At the present time all States except one have had a services plan approved by the Secretary of HEW. It is estimated that about $20 of the $30 million authorized under the law will be spent in fiscal year 1979.

Committee bill.—The committee bill would extend this program for disabled children for an additional three years, through fiscal year 1982. Without such an extension, the program will have no funding after September 30, 1979.

The committee notes that the program is only now becoming fully implemented. The Department of HEW issued final regulations for the program after substantial delay (in April 1979), and, until regulations were effective, States were forced to operate under interim guidelines. Those States which have been able to fully implement their programs have found them to be an effective mechanism for coordinating all available services which a child may need, and assuring that the services are actually received.

The committee believes that the justification for the original enactment of the program is still valid. The committee noted in its report on the enabling legislation:

> The committee believes that there are substantial arguments to support the establishment of a formal referral procedure. Many disabled children have conditions which can be improved through proper medical and rehabilitative services, especially if the conditions are treated early in life. The referral of children who have been determined to be disabled could thus be of very great immediate and long-term benefit to the children and families who receive appropriate services. In addition, the procedure could be expected to result in long-range savings for the SSI program, in that some children, at least, would have their conditions satisfactorily treated and would move off the disability rolls instead of receiving payments for their entire lifetime. The referral of disabled children by the Social Security Administration would also serve as a case-finding tool for community agencies serving disabled children and assist them in focusing their services in behalf of these children. Many communities have the capability to help disabled and handicapped children, but are not always able to identify those with the greatest need.

PUBLIC ASSISTANCE PAYMENTS TO TERRITORIAL JURISDICTIONS

(Section 306 of the Bill)

Present law.—Under existing law there is a dollar ceiling on Federal matching for costs of cash assistance, administration and social services provided under the programs of aid to families with dependent children and aid to the aged, blind, and disabled in the jurisdictions of Puerto Rico, Guam, and the Virgin Islands. The annual permanent ceiling is $24 million for Puerto Rico, $1.1 million for Guam, and $0.8 million for the Virgin Islands. These limits have been in effect since 1972. In addition, these jurisdictions are limited to 50 percent Federal matching, whereas the States may receive from 50 to 83 percent Federal matching, depending on State per capita income.

The average payment in January 1979 for AFDC recipients was $11.92 in Puerto Rico, $55.75 in Guam, and $40.22 in the Virgin Islands, compared to a U.S. average of $86.60 per recipient. Average payments in that same month for the aged in these jurisdictions were $20.02 in Puerto Rico, $74.42 in Guam, and $58.16 in the Virgin Islands, compared to the average federally administered SSI payment of about $131.04.

For one year (fiscal year 1979), the overall ceiling was tripled to about $78 million and the matching rate was increased to 75 percent by an amendment to the Revenue Act of 1978 (Public Law 95-600). This provision expired September 30, 1979, and the ceiling reverts to $26 million and the matching rate to 50 percent.

TABLE 21.—SSI DISABLED AND BLIND CHILDRENS' SERVICES PROGRAM: FEDERAL ALLOCATION BY STATE, FISCAL YEAR 1979

States	Children under age 7	Allotment of funds
Total	22,097,899	$30,000,000
Region I:		
Connecticut	263,513	357,600
Maine	108,017	146,700
Massachusetts	505,574	686,400
New Hampshire	82,078	111,300
Rhode Island	83,666	113,700
Vermont	48,860	66,300
Region II:		
New Jersey	665,208	903,000
New York	1,680,483	2,281,500
Region III:		
Delaware	59,474	80,700
District of Columbia	89,742	121,800
Maryland	372,822	506,100
Pennsylvania	1,078,254	1,463,700
Virginia	497,034	674,700
West Virginia	193,286	262,500
Region IV:		
Alabama	407,836	553,800
Florida	775,176	1,052,400
Georgia	580,813	788,400
Kentucky	381,137	517,500
Mississippi	301,948	409,800
North Carolina	588,036	798,300
South Carolina	330,843	449,100
Tennessee	448,621	609,000
Region V:		
Illinois	1,175,494	1,596,000
Indiana	577,305	783,600
Michigan	964,638	1,309,500
Minnesota	390,302	529,800
Ohio	1,118,524	1,518,600
Wisconsin	450,263	611,400

TABLE 21.—SSI DISABLED AND BLIND CHILDRENS' SERVICES PROGRAM: FEDERAL ALLOCATION BY STATE, FISCAL YEAR 1979—Continued

States	Children under age 7	Allotment of funds
Region VI:		
Arkansas	234,588	318,600
Louisiana	461,961	627,300
New Mexico	145,238	197,100
Oklahoma	290,258	394,200
Texas	1,495,750	2,030,700
Region VII:		
Iowa	281,729	382,500
Kansas	226,223	307,200
Missouri	482,037	654,300
Nebraska	162,243	220,200
Region VIII:		
Colorado	278,709	378,300
Montana	81,820	111,000
North Dakota	70,333	95,400
South Dakota	75,169	102,000
Utah	203,411	276,300
Wyoming	44,170	60,000
Region IX:		
Arizona	275,313	373,800
California	2,160,909	2,933,700
Hawaii	106,665	144,900
Nevada	64,170	87,000
Region X:		
Alaska	52,188	70,800
Idaho	105,318	143,100
Oregon	230,926	313,500
Washington	349,824	474,900

Sources: U.S. Bureau of the Census, Department of Health, Education, and Welfare.

Committee bill.—The committee approved an amendment that provides for a permanent extension of the provisions which were included in Public Law 95–600 on a temporary 1-year basis. This would provide for the following ceiling amounts: Puerto Rico, $72 million; Guam, $3.3 million, and the Virgin Islands, $2.4 million.

PERIOD WITHIN WHICH CERTAIN CLAIMS MUST BE FILED

(Section 307 of the Bill)

Present law.—Current law does not set a time limit on State submission of claims under the welfare, medicaid and social services programs in the Social Security Act.

Committee bill.—The committee approved a provision under which the Social Security Act would be amended effective October 1, 1981, to limit the period of retroactivity for State claims to a full two years under the various titles of the act (that is, it would apply to expenditures for periods starting with fiscal year 1980). However, the provision could not be interpreted so as to limit Federal financial participation in cases involving court-ordered retroactive payments or audit exceptions or adjustments to prior year costs. The Secretary of Health, Education, and Welfare would be able to waive the limitation in other circumstances where he determines there is good reason to do so. While this provision establishes a time limitation on claiming reimbursement for expenditures for fiscal year 1980 and subsequent years, in the view of the committee it does not authorize any change in the treatment of outstanding expenditures for earlier years. The expenditures for such earlier years retain their status as entitlement items for which the Federal Government is obligated by statute to provide appropriate matching.

III. Regulatory Impact of the Bill

In compliance with paragraph 5 of rule XXIX of the Standing Rules of the Senate the following evaluation is made of the regulatory impact which would be incurred in carrying out the bill.

TITLE I

Adoption assistance.—The bill establishes a new adoption assistance program for hard to place children who would otherwise continue in foster care under the aid to families with dependent children (AFDC) program. The regulations to be issued implementing the new adoption assistance program would affect the welfare agency employees and the children who would be eligible for the adoption subsidies and their adoptive parents. While the exact number of individuals affected cannot be estimated with precision, it would appear to be relatively small since the total number of children receiving foster care under the AFDC program is only about 100,000. While the program itself would provide economic assistance to families adopting hard-to-place children, the overall economic impact should be relatively neutral since the objective of the program is to provide the approximate level of assistance to the adoptive family which would have been provided had the child remained in foster care. The provision should generally have minimal impact on personal privacy

96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 96-900

ADOPTION ASSISTANCE, CHILD WELFARE, AND SOCIAL SERVICES

APRIL 23, 1980.—Ordered to be printed

Mr. ULLMAN, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 3434]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 3434) to amend the Social Security Act to make needed improvements in the child welfare and social services programs, to strengthen and improve the program of Federal support for foster care of needy and dependent children, to establish a program of Federal support to encourage adoptions of children with special needs, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SHORT TITLE

SECTION 1. This Act, with the following table of contents, may be cited as the "Adoption Assistance and Child Welfare Act of 1980".

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Sec. 1. Short title.

TITLE I—FOSTER CARE AND ADOPTION ASSISTANCE

Sec. 101. Federal payments for foster care and adoption assistance.
Sec. 102. Federal payments for dependent children voluntarily placed in foster care.
Sec. 103. Child-welfare services.

TITLE II—SOCIAL SERVICES

Sec. 201. Determination of amount allocated to States.
Sec. 202. Extension of 100-per-centum Federal matching for child day care expenditures.
Sec. 203. Limitation on funds for training.
Sec. 204. Use of restricted private funds for training programs.
Sec. 205. Emergency shelter.
Sec. 206. Multiyear plan; choice of fiscal year.
Sec. 207. Social services funding for territories.
Sec. 208. Permanent extension of provisions relating to child day care services and WIN tax credit.
Sec. 209. Permanent extension of provisions relating to services for alcoholics and drug addicts.

TITLE III—OTHER SOCIAL SECURITY ACT PROVISIONS

Sec. 301. Permanent extension of provisions relating to child support enforcement.
Sec. 302. Incentives to report earnings under AFDC programs.
Sec. 303. Prorating of shelter allowance.
Sec. 304. Services for disabled children.
Sec. 305. Public assistance payments to territorial jurisdictions.
Sec. 306. Period within which certain claims must be filed.
Sec. 307. Incentives for States to collect child support obligations.
Sec. 308. Exchange of information on terminated or suspended providers.
Sec. 309. Postponement of imposition of certain penalties relating to child support requirements.
Sec. 310. Continuing medicaid eligibility for certain recipients of Veterans' Administration pensions.

TITLE I—FOSTER CARE AND ADOPTION ASSISTANCE

FEDERAL PAYMENTS FOR FOSTER CARE AND ADOPTION ASSISTANCE

SEC. 101. (a)(1) Title IV of the Social Security Act is amended by adding at the end thereof the following new part:

"PART E—FEDERAL PAYMENTS FOR FOSTER CARE AND ADOPTION ASSISTANCE

"PURPOSE; APPROPRIATION

"SEC. 470. For the purpose of enabling each State to provide, in appropriate cases, foster care and adoption assistance for children who otherwise would be eligible for assistance under the State's plan approved under part A (or, in the case of adoption assistance, would be eligible for benefits under title XVI), there are authorized to be appropriated for each fiscal year (commencing with the fiscal year which begins October 1, 1980) such sums as may be necessary to carry out the provisions of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans under this part.

"STATE PLAN FOR FOSTER CARE AND ADOPTION ASSISTANCE

"SEC. 471. (a) In order for a State to be eligible for payments under this part, it shall have a plan approved by the Secretary which—

"(1) provides for foster care maintenance payments in accordance with section 472 and for adoption assistance payments in accordance with section 473;

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TITLE I—FOSTER CARE AND ADOPTION ASSISTANCE

Establishment of a Separate Foster Care (and Adoption Assistance) Program Under a New Part E of Title IV of the Social Security Act

(Sec. 101)

Present law.—Title IV–A of the Social Security Act provides Federal matching for State payments for foster care. States are required to make foster care payments as part of their AFDC program.

House bill.—The House bill retained present law provisions for Federal matching of foster care under Title IV–A, with amendments (including provisions for adoption assistance).

Senate bill.—The Senate bill provided repealed the current Title IV–A authorization for Federal AFDC foster care matching funds and the requirement that States have an AFDC foster care program. The bill created a new Part E of Title IV, "Federal Payments for Adoption Assistance and Foster Care," under which States would have the option of making foster care payments (and adoption assistance). In addition, under the Senate bill Federal matching funds would not be available for children placed in foster care after September 30, 1984.

Conference agreement.—Under the conference agreement, the present IV–A AFDC foster care program would be shifted to a new Title IV–E, as under the Senate bill, but would continue to be a required program as under current law. States could shift AFDC foster care from IV–A to the new Title IV–E program as of October 1, 1980 and would be required to have made the transition by October 1, 1982. Authority for Federal IV–E foster care matching funds would be permanent, as under the House bill.

New Foster Care (and Adoption Assistance) State Plan Requirements

1. Administration

(Sec. 101)

Present law.—The State plan requirements that apply to AFDC are generally also applicable to AFDC foster care. These include requirements relating to administration, personnel standards, reporting, privacy, benefit standards, and others.

House bill.—Same as present law.

Senate bill.—The Senate bill provided that, in order for a State to be eligible for payments for foster care and adoption assistance under the new Title IV–E, it must have a plan approved by the Secretary

which provides that, in addition to certain State plan administrative requirements in current law, the agency responsible for administering the Title IV–B child welfare program shall administer or supervise the administration of the new program.

Conference agreement.—The House recedes.

2. Disclosure of Information

(Sec. 101)

Present law.—Current law restricts the use or disclosure of information to purposes directly connected with: AFDC, SSI, Medicaid, or the Title XX social services program; any investigation, prosecution, or criminal or civil proceeding related to the administration of these programs; or the administration of any other federally assisted program providing assistance or services based on need. Present law also prohibits the disclosure to any committee or legislative body of information which identifies by name or address any applicant for, or recipient of, such assistance or services.

House bill.—Same as present law.

Senate bill.— The Senate bill modified present law to allow the disclosure of information regarding individuals assisted under the State's foster care and adoption assistance plan (1) for purposes of any authorized audit conducted in connection with the administration of the program including an audit performed by a legislative audit body, and (2) to the Committee on Finance and the Committee on Ways and Means. The bill also added language stating that nothing in the amendment shall preclude a State from providing standards which restrict disclosures to purposes more limited than those specified, or which, in the case of adoptions, prevent disclosure entirely.

Conference agreement.—The House recedes with an amendment. The conference agreement includes the provisions of the Senate bill, except that disclosure of information containing names and addresses of individual recipients to the Committees on Finance and Ways and Means would not be authorized. The conferees note that this limitation pertains only to names and addresses. As under existing law, the two committees would otherwise have full access to data and findings concerning the operations of these programs and would be able to request and receive the results of program audits. In addition, disclosure for purposes of the independently conducted audits required by other provisions of this bill would be authorized.

3. Required Audit or Evaluation of State's Foster Care, Child Welfare Services and Adoption Assistance Programs

(Sec. 101)

House bill.—No provision.

Senate bill.—The Senate bill would require a State to arrange for a "periodic and independently conducted audit" of Federally assisted AFDC foster care, adoption assistance and Title IV–B child welfare services programs at least once every three years. It would also require that the State agency periodically evaluate the foster care and adop-

tion assistance programs and review the standards for foster care homes and institutions and the appropriateness of the amount paid for foster care and adoption assistance.

Conference agreement.—The House recedes with the understanding that the required independently conducted audit may be performed by a governmental agency.

4. Hearing Procedures

(Sec. 101)

Present law.—The AFDC law requires that States must provide a fair hearing to any individual whose claim for aid is denied or not acted on with reasonable promptness. Specific requirements for fair hearing procedures are established in Federal regulations which provide that, in the case of an adverse determination, the State must give timely and adequate notice. Notice must be mailed at least 10 days before the effective date of the action and benefits must be continued if the recipient asks for a hearing within the 10 day period.

House bill.—Same as present law.

Senate bill.—The Senate bill required that any individual who is denied a request for benefits under Part E or under the IV–B child welfare program be informed of the reasons for the denial and offered an opportunity to meet with a representative of the agency.

Conference agreement.—The conference agreement provides that hearing procedures under the new IV–E program would be the same as under current IV–A law.

5. Procedure and Requirements Related to Children in Foster Care in Excess of 24 Months

(Sec. 101)

House bill.—No provision.

Senate bill.—The Senate bill required a State to:

(1) establish by State law by October 1, 1981, for each fiscal year beginning with FY 1983, specific goals as to the maximum number of children (absolute number or by percent of foster care children) who at any time during such year will be in foster care after having been in foster care over 24 months, and

(2) describe the steps which will be taken by the State to achieve the State's goals.

Conference agreement.—The House recedes with an amendment to the effective date. The State must establish its goals by October 1, 1982 for fiscal years beginning with fiscal 1984.

6. Case Plan and Case Review System

(Sec. 101)

Present law.—Current law requires the development of a case plan for each IV–A foster care child, and a "periodic review of the necessity for the child's being in a foster family home or child care institution."

House bill.—The House bill specified that the case plan must be a written document which includes a description of the child's placement and its appropriateness; a plan, if necessary, for compliance with judicial determination requirements; and a plan of services which will be provided in order to improve family conditions and facilitate returning the child to his home, or which will facilitate other permanent placement of a child, or which will serve the needs of a child while in foster placement. In addition, it required a case review at least every six months by a court of competent jurisdiction or an administrative review.

Senate bill.—The Senate bill included the same case plan requirements as the House bill. However, it maintained the current law provisions for "periodic review."

Conference agreement.—The Senate recedes.

7. Preventive and Reunification Services

(Sec. 101)

Present law.—Current law requires the development of a case plan for each child to assure that the child "receives proper care and that services are provided which are designed to improve the conditions in the home from which he was removed or to otherwise make possible his being placed in the home of a relative."

House bill.—Same as present law.

Senate bill.—The Senate bill provided that in order for the State to have an approved State plan under Title IV–E after October 1, 1981, the State plan must provide that in each case:

—reasonable efforts will be made prior to the placement of the child in foster care to prevent or eliminate the need for removal of the child from his home; and

—reasonable efforts will be made to make it possible for the child to return to his home.

Conference agreement.—The House recedes with an amendment which retains the current law requirement assuring that the child receives proper care. The conferees agreed to the Senate requirement beginning October 1, 1983.

8. Federal Sanctions for Non-Compliance With State Plan Requirements

(Sec. 101)

Present law.—Present law provides for the denial of Federal matching for part or all of the State's AFDC program if there is a finding by HEW of substantial failure to comply with the AFDC State plan requirements.

House bill.—Same as present law.

Senate bill.—The Senate bill provided that if there is a finding by HEW of substantial failure to comply with the State plan requirements under the new Part E of Title IV for foster care and adoption assistance, HEW could reduce the Federal matching payments to the extent determined to be appropriate.

Conference agreement.—The House recedes.

Ceiling on Federal Matching for Foster Care

(Sec. 101)

Present law.—Under present law, Federal matching funds for AFDC foster care are available to States on an open-ended, entitlement basis.

House bill.—Same as present law.

Senate bill.—The Senate bill provided for a ceiling on the amount of Federal matching funds available to each State for AFDC foster care maintenance payments, including related administrative expenses, for fiscal years 1980 through 1984. The ceiling for a State in fiscal year 1980 would be the greatest of: 120 percent of the 1978 Federal matching funds for AFDC foster care, including related administrative expenses; 1979 Federal matching funds for AFDC foster care for a State, including related administrative expenses, increased by the greater of 10 percent or the increase in the CPI; or a State's share of $100 million relative to its population under age 18.

In applying the above, a State's base would include that additional amount of money a State would have been entitled to be paid for foster care maintenance payments on behalf of children whose foster care was provided by related persons and whose placement met the other requirements of law if such payments had been made. Certain disputed claims would also be included in the base until they are resolved.

The ceiling for a State in fiscal 1981 through 1984 would be the greater of: 110 percent of the preceding year's ceiling; or a State's share of $100 million relative to its populations under age 18.

Any funds made available to a State for foster care under this ceiling which are not used for Title IV–E foster care could be used to provide child welfare services under Title IV–B at the 75 percent Federal matching rate.

Conference agreement.—The House recedes with an amendment. Under the conference agreement, there would be a ceiling on Federal foster care matching funds for four years beginning with fiscal 1981.

States would have the following options in the determination of this ceiling:

1. The State's fiscal year 1978 Federal foster care funds increased by 33⅓ percent for fiscal year 1981, and increased by 10 percent per year thereafter.

2. The State's share of $100 million relative to its population under 18.

3. Or, a State whose AFDC foster care caseload in fiscal year 1978 was below the 1978 national average AFDC foster care caseload (based on the percentage of children under 18 in AFDC foster care in the State and nationwide) could receive an amount for 1981, and for each year thereafter (1982–1984) that its foster care caseload remained below the 1978 national average caseload, determied as follows: for each year, the amount of Federal AFDC foster care matching funds the State received in 1978 would be increased (1) by the same percentage its AFDC foster care caseload had increased since 1978 not to exceed 10 percent per year from 1978 to the year in question) and (2) further increased by 33⅓ percent for fiscal year 1981 and by

10 percent per year thereafter. This option would not be available to a State once its foster care caseload equals or exceeds the 1978 national average caseload.

Under all options, a State's base would include the cost of certain foster care provided by related persons and certain disputed claims, as in the Senate bill.

The ceiling on Federal foster care funds would not be effective for fiscal year 1981 if IV–B child welfare services appropriations are less than $163.5 million, for fiscal year 1982 if IV–B appropriations are less than $220 million, and for fiscal years 1983 and 1984 if IV–B appropriations are less than $266 million. Further, beginning with fiscal year 1981 for expenditures in fiscal year 1982, IV–B appropriations must be provided on an advance funding basis.

Federal foster care matching funds made available to a State under the ceiling which are not used for foster care maintenance could be used for IV–B child welfare services at the 75 percent Federal matching rate under the following conditions:

—A State that selected the ceiling option No. 3 described above could not transfer IV–E foster care funds to IV–B child welfare services.

—A State could not transfer from IV–E to IV–B more than an amount which, together with the IV–B funds it receives, exceeds its share of $141 million under the IV–B allocation formula, unless and until it had implemented the foster care procedures and protections, except preplacement preventive services, required by section 103 of this bill in order for a State to receive additional IV–B child welfare services funds. (These required procedures and protections are described in the part of section 103 entitled "Requirements for Additional Federal IV–B Child Welfare Services Funds.") After Federal IV–B appropriations have equaled the authorized maximum of $266 million for two consecutive years, a State could not transfer funds from IV–E to IV–B unless and until it had implemented all the foster care procedures and protections required for receipt of additional IV–B child welfare services funds, including a program of preplacement preventive services.

In any year there is no ceiling on Federal IV–E foster care funds because of inadequate IV–B appropriations, a State that opted for a ceiling in order to be able to transfer funds from IV–E to IV–B could not transfer more than an amount which, together with the IV–B funds it receives, exceeds the amount of IV–B funds it would have received if the IV–B appropriations for such year had been sufficient to require a ceiling on foster care funds in all States. Further, the State could not transfer from IV–E to IV–B more than an amount which, together with the IV–B funds it receives, exceeds its share of $141 million under the IV–B allocation formula, unless and until it had implemented the foster care procedures and protections required in order for a State to receive additional IV–B child welfare service funds, except preplacement preventive services. When for any two fiscal years the amount of funds transferred from IV–E to IV–B plus direct IV–B funds has equaled the State's share of $266 million (under the IV–B allocation formula), the State could no longer transfer funds

from IV–E to IV–B unless and until it had implemented all the foster care procedures and protections required for receipt of additional IV–B child welfare services funds, including a program of preplacement preventive services.

Provision of Preventive Services for Children Placed as a Result of Judicial Determination

(Sec. 101)

Present law.—Under present law, Federal IV–A matching funds are available for foster care maintenance payments for a child (1) who has been removed from the home of a relative and placed in a foster family home or child care institution as a result of a judicial determination that continuation in that home would be contrary to the child's welfare, and (2) who received AFDC during the month in which court proceedings were initiated or was eligible to receive AFDC in that month or within 6 months prior to that time.

House bill.—The House bill maintained present law for IV–A matching funds. (However, one of the new requirements a State would have to meet to continue to receive additional IV–B funds is that judicial determinations in the case of involuntarily removed children would have to establish, among other findings, that there had been reasonable attempts to provide preplacement preventive services.)

Senate bill.—The Senate bill provided that under the new IV–E program the current judicial determination requirement would be modified to include a judicial finding that reasonable efforts have been made to prevent the need for the child's removal from his home or, where applicable, to make it possible for the child to return to his home.

Conference agreement.—The House recedes. The modification in the Senate bill would become effective October 1, 1983. (The conference agreement also provides for Federal funding for certain "voluntarily" placed children as described in the part of section 102 entitled "Children Voluntarily Placed in Foster Care.")

Definition of Foster Care Maintenance Payments

(Sec. 101)

Present law.—In present law, there is no general definition covering all "foster care maintenance payments." However, payments on behalf of children in an institution are subject to limitations prescribed by the Secretary with a view to including only those items which are included in the case of foster care provided in a foster family home.

House bill.—No provision.

Senate bill.—The Senate bill defined "foster care maintenance payments" as payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, personal incidentals, liability insurance for the child, and reasonable travel to the child's home for visits. In the case of institutional care, the term would include the reasonable costs of administration and operation of the institution as are required to provide the items listed above.

Conference agreement.—The House recedes with the understanding that, in the case of foster family homes, payments for the costs of providing care to foster children are not intended to include reimbursement in the nature of a salary for the exercise by the foster family parent of ordinary parental duties.

Foster Care Maintenance Payments to Children in Homes and Institutions

(Sec. 101)

Present law.—Present law authorizes matching for maintenance payments made to children who are living in foster family homes and in nonprofit *private* child care institutions.

House bill.—The House bill allowed matching for maintenance payments made to children in *public* institutions which accommodate no more than 25 children (but not including detention facilities, forestry camps, training schools, or any other facilities operated primarily for the detention of children who are delinquent). The change applied to children already in such institutions on the date of enactment and to those placed after enactment.

Senate bill.—The Senate bill included the same provision, except that it applied only to children placed in qualified public institutions after the date of enactment.

Conference agreement.—The Senate recedes.

Federal Matching Provisions for Foster Care

(Sec. 101)

Present law.—Under present law, States receive Federal matching for AFDC foster care payments on the same basis as matching for regular AFDC payments. They may use (1) the AFDC formula, which is used by only 4 States, or (2) the Medicaid formula.

House bill.—Same as present law.

Senate bill.—The Senate bill provided for Federal matching under the new IV-E program according to the Medicaid matching formula.

Conference agreement.—The House recedes.

Children Voluntarily Placed in Foster Care

(Sec. 102)

Present law.—Under present law, Federal AFDC matching funds are not available for children placed in foster care without a judicial determination.

House bill.—The House bill removed the limitation that only children who have been placed in foster care as the result of a judicial determination may receive federally matched foster care payments. It allowed Federal matching for children who have been removed from the home pursuant to a voluntary placement agreement, but only after the Secretary of HEW had determined that a State had in place all of the protection and procedures required by section 103 of this bill for the receipt of additional IV-B child welfare services funds.

Senate bill.—The Senate bill maintained the present law limitation.

Conference agreement.—The Senate recedes with an amendment. The conference agreement provides that, in those States that have implemented the protections and procedures required by section 103 for receipt of additional IV–B child welfare services funds, including a program of preplacement preventive services. Federal foster care matching funds would be available until September 30, 1983 for children who have been voluntarily removed from their home (without a judicial determination), if such removal is pursuant to a voluntary placement agreement. The voluntary placement agreement must be revokable on the part of the parent unless the child welfare agency objects and obtains a judicial determination that the return of the child to the home would be contrary to the child's best interests. There would have to be a judicial determination of a voluntary placement within six months to the effect that such placement is in the best interests of the child. The Secretary of HEW would be required to report annually to the Congress on the number of children placed under this provision.

Certain Voluntarily Placed Children

(Sec. 102)

House bill.—The bill provided that a child who was voluntarily removed from the home prior to enactment of the bill without a judicial determination would, upon enactment, become eligible for Federally matched foster care payments in the future, but only if (1) the State had implemented the protections and procedures referred to above (except preplacement preventive services) and (2) there was a written individualized case plan for that child which had been prepared and reviewed according to specified procedures.

Senate bill.—The Senate bill provided that Federal matching under the new Title IV–E would be allowed for a child who was voluntarily removed from the home and for whom there had been, at some time prior to October 1, 1978, a judicial determination that continuation in the home would have been contrary to the welfare of the child. Federal matching funds would become available from the date that a case plan was prepared and a case review was made regarding the child. The bill also authorized Federal matching under Title IV–A until such time as a State had an approved plan under the new Title IV–E for certain children voluntarily placed prior to October 1, 1979. Federal matching would be provided for AFDC foster care costs in the case of a child removed from the home on a voluntary basis where, prior to October 1, 1978, there was a judicial determination that continuation in the home would have been contrary to the welfare of such child. The date of the voluntary removal would be deemed to be the date on which the court proceedings were initiated.

Conference agreement.—The House recedes.

Provision for State Adoption Assistance Program

(Sec. 101)

Present law.—There is no requirement in present law that States have a program of adoption assistance.

House bill.—The House bill required that States establish no later than September 1, 1980 an adoption assistance program under which adoption assistance payments would be made and AFDC Federal matching funds could be claimed under certain conditions and limitations.

Senate bill.—The Senate bill provided that, as part of its IV–E plan, a State may establish an adoption assistance program and receive Federal matching funds under certain conditions and limitations.

Conference agreement.—The Senate recedes with an amendment. Under the conference agreement States would be required to establish an adoption assistance program under the new Title IV–E no later than October 1, 1982.

Eligibility for Adoption Assistance

(Sec. 101)

House bill.—The House bill authorized Federal matching for payments to parents who adopt a child with "special needs" who, prior to adoption, was eligible for SSI or AFDC (including AFDC foster care pursuant to a judicial determination or voluntary placement agreement). The bill also provided that a child could not be considered a child with "special needs" unless the State agency determined that the child could not or should not be returned to his biological family; that the child was difficult to place because of his ethnic background, age, membership in a minority or sibling group, or the presence of factors such as medical conditions or physical, mental, or emotional handicaps; and that a reasonable but unsuccessful effort had been made to place the child without providing assistance.

Senate bill.—The Senate bill authorized Federal matching for payments to parents who adopt a child with "special needs" who, prior to adoption, was eligible for SSI or AFDC foster care pursuant to a judicial determination. The Senate bill also provided that a child could not be considered a child with special needs unless the State agency had determined that the child could not or should not be returned to his home; the State determined that there existed with respect to the child a specific factor or condition because of which it was reasonable to conclude that the child cannot be placed without providing adoption assistance; and that a reasonable but unsuccessful effort had been made to place the child without providing assistance.

Conference agreement.—The conference agreement provides that Federal matching would be available for a child with "special needs" who was eligible for SSI, AFDC or AFDC foster care, including voluntarily placed children, as under the House bill. "Special needs" would be defined as in the Senate bill, modified by House language to provide examples of the kinds of factors or conditions that could constitute "special needs."

Adoption Assistance Agreements

(Sec. 101)

House bill.—The House bill provided federal matching for adoption assistance payments pursuant to an adoption assistance agreement.

It defined "adoption assistance agreement" to mean a written statement, binding on all parties, between the State agency, other relevant agencies, and the prospective adopting parents, which specifies, at a minimum, the amount of payments and any additional services and assistance which are to be provided. In addition, the bill required that the agreement shall remain in effect regardless of whether the adoptive parents are or remain residents of the State.

Senate bill.—The Senate bill included the same provision as the House bill, with the exception that it omitted the requirement that the agreement remain in effect regardless of whether the adoptive parents are or remain residents of the State.

Conference agreement.—The Senate recedes with an amendment providing that, effective October 1, 1983, States would be required to continue to comply with adoption assistance agreements regardless of whether the adoptive parents are or remain residents of the State, as in the House bill. Between enactment and October 1, 1983, HEW would be directed to develop interstate compacts with respect to adoption assistance agreements.

Amount of Adoption Assistance Payments

(Sec. 101)

House bill.—The House bill provided that the amount of the payments would be determined through agreement between the parents and the agency, taking into consideration the economic or other circumstances of the adopting parents and the needs of the child being adopted, and could be readjusted periodically depending on changes in circumstances. The bill also provided that adoption assistance payments could include payments of an amount necessary to cover part or all of the *nonrecurring* expenses (as defined in regulations of the Secretary) associated with the proceedings related to the adoption of the child.

Senate bill.—The Senate bill included the same provision with respect to the amount of payments, but stipulated that funds expended with respect to *nonrecurring* costs of adoption proceedings could be paid for with Title IV–B child welfare services funds, but not with open-ended funds for adoption assistance payments.

Conference agreement.—The House recedes. The conferees understand that some States already fund certain costs associated with adoption through the child welfare services program. This provision is not intended to prohibit funding for expenditures which are considered eligible for funding under present law, such as costs associated with the adoption of children who do not meet the requirements for adoption assistance under the new program established under Title IV–E.

Duration of Adoption Assistance

(Sec. 101)

House bill.—The House bill provided that adoption assistance payments could continue until the child reached age 18. In the case of a child with a physical or mental handicap, the State could continue with assistance until the child reached age 21. Adoption assistance

payments to adoptive parents would cease prior to age 18 (or 21) if the State determines that the child is no longer receiving any support from such parents.

Senate bill.—The Senate bill provided that adoption assistance payments could continue until the child reached age 18. In addition, the bill provided that adoption assistance payments to adoptive parents would cease if the State determined that—

—the child was no longer receiving any support from such parents; or

—the parents were no longer legally responsible for the support of the child.

Conference agreement.—The conferees agreed that Federally matched adoption assistance could continue until the child reached 18, or until 21 in the case of a child with a mental or physical handicap, as in the House bill. Federally matched adoption assistance payments would stop if the State determines the parents are no longer supporting the child or are no longer legally responsible for supporting the child, as in the Senate bill.

Medicaid Eligibility for Adopted Children

(Sec. 101)

House bill.—The House bill provided that children receiving adoption assistance payments would be considered to be receiving AFDC and therefore would be categorically eligible for Medicaid.

Senate bill.—The Senate bill provided that children eligible for adoption assistance would be covered under Medicaid.

Conference agreement.—The Senate recedes.

Federal Matching for Adoption Assistance

(Sec. 101)

House bill.—The House bill provided permanent Federal matching funds for adoption assistance. Matching would be the same as for AFDC, using either the AFDC or Medicaid formula.

Senate bill.—The Senate bill provided that Federal matching for adoption assistance would be limited to adoption assistance agreements entered into before October 1, 1984. Matching would be based on the Medicaid formula.

Conference agreement.—The conference agreement provides that Federal matching for adoption assistance would be permanent, as in the House bill, and would be based on the Medicaid matching formula, as in the Senate bill.

HEW Responsibilities for Studies and Technical Assistance

(Sec. 101)

House bill.—No provision.

Senate bill.—The Senate bill authorized the Secretary of HEW to provide technical assistance to the States in implementing the new Title IV–E. It further required him to conduct a study of foster care

and adoption assistance programs established under the new part IV–E and to submit a report to the Congress by October 1, 1982, including an analysis and evaluation of the effectiveness of the new Title IV–E, and recommendations as to whether the program should continue or any recommendations regarding changes needed in the program.

Conference agreement.—The House recedes. HEW would be authorized to provide technical assistance to States, and to conduct a study of the new IV–E program with a report to Congress, as in the Senate bill. The report would be due October 1, 1983.

TITLE IV-B CHILD WELFARE SERVICES

Requirements for Additional Federal IV-B Child Welfare Services Funds

(Sec. 103)

Present law.—Current law authorizes up to $266 million annually, subject to appropriations, for IV-B child welfare services matching funds to be allocated among the States on the basis of the child population and per capita income of each State. Annual appropriations have never exceeded $56.5 million. Appropriated funds may be used for foster care maintenance payments and a wide variety of child welfare services.

House bill.—The bill provided that in fiscal years 1980 and 1981, if appropriated, States could receive up to $84 million in excess of $56.5 million currently appropriated for child welfare services. In order to continue to receive its share of these new funds beyond fiscal year 1981, a State would have to have implemented specified laws and procedures to assure: judicial determinations in the case of involuntary placements, which would include a finding with regard to the provision of preplacement preventive services; "voluntary placement agreements" in the case of voluntary placements; reunification services; placements in the least restrictive setting and within reasonable proximity to home; a case plan for each child in foster care (6 month administrative review and 18 month dispositional hearing); and fair hearing procedures.

Beginning in fiscal year 1981, if appropriated, a State could receive its share of an additional $125.5 million if, in addition to the above items, it had: completed case reviews of all children who have been in foster care for over 6 months; and provided HEW with an inventory and report based on these case reviews. In order for a State to continue to receive its share of this second allotment of new funds beyond the end of the fiscal year following the fiscal year it received such funds, it would have to have: implemented "preplacement preventive services" for voluntary and involuntary placements; established procedures enabling it to provide HEW with an annual report on children in foster care; and demonstrated that 40 percent of additional IV-B funds are used for preventive and reunification services.

Senate bill.—The bill provided that, if in any year funds in excess of $56.5 million are appropriated, the appropriations act may restrict States' use of such new funds to certain foster care procedures and services. This included for the first year: conducting an inventory of children who have been in foster care for over 6 months; developing a statewide information system on children in foster care; developing a case review system for each child in foster care (12 month review and 24 month dispositional hearing), designed to achieve placement in the least restrictive setting and in close proximity to home, and to provide

procedural safeguards for parents; and developing a service program designed to help children remain with their families or, where possible, return to their families. In any following fiscal year, the additional IV–B funds could be used for the implementation and operation of the information and case review system and service programs referred to above. However, if a State had completed all the activities referred to above, any amounts available to it in any fiscal year in excess of the $56.5 million appropriation could be used for implementation and operation.

Conference agreement.—In any year in which Federal IV–B appropriations exceed $141 million, a State could not receive any IV–B funds in excess of its share of $141 million unless it had implemented the following procedures and protections:

—conducted an inventory of children who have been in foster care for over 6 months

—implemented a statewide information system on children in foster care

—implemented a case review system for each child in foster care, which includes a 6 month review and 18 month dispositional hearing for each child. The case review system must be designed to achieve placement in the least restrictive setting and in close proximity to home, and to provide procedural safeguards for children, parents and foster care providers

—implemented a services program designed to assist children, where possible, to return to their homes.

Further, when Federal IV–B appropriations have equalled the authorized maximum of $266 million for two consecutive years, a State would have its IV–B funds reduced, beginning with the succeeding fiscal year, to the share of $56 million it received in fiscal year 1979, unless and until it had implemented the protections and procedures described above and, in addition, implemented a service program of preplacement preventive services designed to prevent the need for removing a child from his or her home.

Definition of Child Welfare Services

(Sec. 103)

Present law.—For purposes of Title IV–B, the term "child welfare services" is defined as public social services which supplement, or substitute for, parental care and supervision for the purpose of—(a) preventing or remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation or delinquency of children; (b) protecting and caring for homeless, dependent, or neglected children; (c) protecting and promoting the welfare of children of working mothers; and (d) otherwise protecting and promoting the welfare of children, including the strengthening of their own homes where possible or, where needed, the provision of adequate care of children away from their homes in foster family homes or day care or other child care facilities.

House bill.—The bill changed the definition of "child welfare services" to public social services which are directed toward the accomplishment of the following purposes: (a) preventing or remedying or assisting in the solution of problems which may result in, the neglect, abuse, exploitation or delinquency of children; (b) protecting and

promoting the welfare of all children, including handicapped, homeless, dependent, or neglected children; (c) preventing the unnecessary separation of children from their families by identifying problems, assisting families in resolving their problems, and preventing breakup of the family where the prevention of child removal is desirable and possible; (d) restoring to their families children who have been removed, by the provision of services to the child and family; (e) placing children in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate; and (f) assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption.

Senate bill.—No provision.

Conference agreement.—The Senate recedes.

Limitations on Use of Title IV–B Funds

(Sec. 103)

House bill.—The bill prohibited a state from using any funds it received in excess of its share of the $56.5 million currently appropriated for foster care maintenance payments, adoption assistance payments, and for child care which is solely employment-related.

Senate bill.—The bill prohibited a State from using any funds, in excess of it share of the $56.5 million currently appropriated, for foster care maintenance payments.

Conference agreement.—A State would be prohibited from using new IV–B funds for foster care maintenance payments, adoption assistance, and for child care that is needed only for employment, as in the House bill.

Prohibition Against Reduction of State Child Welfare Expenditures

(Sec. 103)

House bill.—The House bill provided that to be eligible to receive its share of increased appropriations under Title IV–B, a state could not reduce its spending level for child welfare services under Title XX and Title IV–B, below its 1979 level.

Senate bill.—No provision.

Conference agreement.—The Senate recedes with an amendment. Under the conference agreement, the reference to Title XX would be omitted.

Federal Matching Rate for IV–B Child Welfare Services

(Sec. 103)

Present law.—Current Federal matching rates range from 33⅓ percent to 66⅔ percent based upon State per capita income.

House bill.—The Federal matching rate for Title IV–B funds would be changed to 75 percent.

Senate bill.—Same as House bill but a State would be allowed to use State foster care expenditures to meet the 25 percent IV–B matching requirement.

Conference agreement.—The House recedes.

Advance Funding of Title IV–B

(Sec. 103)

House bill.—No provision.

Senate bill.—The bill converted the child welfare services program to an "advance funding" basis. Appropriations would become available for expenditure in the fiscal year following the fiscal year to which the appropriation act generally applied in order to provide States with advance knowledge of the amount of funding available.

Conference agreement.—IV–B funds would be shifted to an advance funding basis as in the Senate bill beginning in fiscal year 1981 for expenditures to be made in 1982.

Carryover of a State's Unused Title IV–B Child Welfare Funds

(Sec. 103)

House bill.—Funds appropriated for fiscal year 1980 would remain available, to the extent provided in an appropriation act, through fiscal year 1981.

Senate bill.—No provision.

Conference agreement.—The Senate recedes.

Reallocation of Title IV–B Funds

(Sec. 103)

Present law.—Current law permits reallocation of funds not needed by one State to other States which the Secretary determines have need for such funds to carry out their State plans and which will be able to use such funds during the fiscal year. Reallocation is to take into consideration the population under age 21 of each State and the State per capita income.

House bill.—The bill repealed the present law provision for reallocation of unused funds.

Senate bill.—Same as present law.

Conference agreement.—The House recedes.

Child Welfare Payments Directly to Indian Tribal Organizations

(Sec. 103)

Present law.—There is no specific provision relating to Indian tribal organizations.

House bill.—Same as present law.

Senate bill.—The bill provided authority for the Secretary of HEW to make payments from funds appropriated for Title IV–B child welfare services directly to an Indian tribal organization in a State. The payments would come from the State's Title IV–B allotment.

Conference agreement.—The House recedes.

TITLE II—SOCIAL SERVICES

Ceiling on Federal Title XX Funds

(Sec. 201)

Present law.—For fiscal year 1979, Federal funding for social services under Title XX of the Social Security Act was subject to a temporary national ceiling of $2.9 billion. As of October 1, 1979, the ceiling reverted to its permanent level of $2.5 billion.

House bill.—The House bill provided for increasing the permanent ceiling on Federal funding for Title XX to $3.1 billion for fiscal year 1980 and after.

Senate bill.—The Senate bill provided for annual indexing of the $2.5 billion ceiling through FY 1985, resulting in the following levels: $2.7 billion in 1980; $2.9 billion in 1981; $3.0 billion in 1982; $3.1 billion in 1983; $3.2 billion in 1984; $3.3 billion in 1985 and after.

Conference agreement.—The House recedes with an amendment requiring reallocation of any unused funds in fiscal year 1980.

100 Percent Matching For Child Day Care; Grants to Hire Welfare Recipients

(Sec. 202)

Present law.—For fiscal years 1977, 1978 and 1979, $200 million annually was available for day care under Title XX with no Federal matching requirement. Under temporary provisions of law which expired March 31, 1980, States were permitted to use Title XX funds to make grants to employers for the wages of welfare recipients hired to provide day care services, under certain specified limitations and restrictions. Grants could be used to pay wages up to $6,000 a year to an employee in the case of a public or nonprofit provider of child care, or $5,000 in the case of a profitmaking provider.

House bill.—The House bill provided that, of the total amount of Title XX funds available under the statutory ceiling, $200 million would be available for child care in fiscal years 1980 and 1981 with no State matching requirement. In addition, the House bill extended through fiscal years 1980 and 1981, the temporary provision of law permitting States to use their share of the $200 million for grants to reimburse employers for wages paid to welfare recipients hired as child care workers.

Senate bill.—The Senate bill, like the House bill, earmarked $200 million for child care in fiscal years 1980 and 1981 with no State matching requirement. In addition, the Senate bill made permanent the same provision permitting States to use Title XX funds for reimbursement of the costs of hiring welfare recipients in child care jobs

with the addition of the following provisions: (a) for fiscal year 1979, States would be limited to their share of the $200 million earmarked for child care; (b) for fiscal years 1980 and 1981, such reimbursement would first be applied to the $200 million child care allocation, and, in any case, could not exceed 8% of the State's share of Title XX Federal funding, with no State matching requirement; (c) for fiscal years 1982 and after, up to 8% of the State's share of total Title XX Federal funding, with no State matching requirement, would be available.

The wage limits would be increased on a permanent basis to $6,000 per eligible employee in public and nonprofit private child care facilities and to $5,000 in profitmaking facilities.

Conference agreement.—Of the total amount of Title XX funds available under the statutory ceiling, $200 million would be available for child care in fiscal 1980 and 1981 with no State matching requirement, as in both the House and Senate bills. In addition, authority for States to use Title XX funds for grants for hiring welfare recipients as child day care workers would be made permanent with the modifications contained in the Senate bill. For fiscal years 1982 and thereafter, a State could receive up to 8 percent of its Title XX allotment with no matching requirement if such allotment was used for child care services (including grants to hire welfare recipients) as provided under present law for the $200 million earmarked for child care services.

Limitation on Funds for Title XX Training

(Sec. 203)

Present law.—75 percent Federal matching funds are available to States on an entitlement basis for training costs related to Title XX activities. These funds are open-ended and are in addition to matching funds provided under the Title XX statutory ceiling.

House bill.—The House bill provided that, for fiscal 1980, Federal matching funds for training would be limited to an amount equal to 3 percent of the State's fiscal 1980 allotment of funds under the statutory services ceiling. States that received more Federal Title XX training funds in fiscal 1979 than 3 percent of their fiscal 1980 allotment would receive an additional amount equal to two-thirds of the amount by which Federal training funds received in fiscal 1979 exceeded 3 percent of their fiscal 1980 allotment. Beginning in fiscal 1981 and for each year thereafter, States would be reimbursed only for those training expenditures that had been included in, and approved by HEW as part of, a State Title XX training plan.

Senate bill.—The Senate bill provided that for fiscal year 1980, notwithstanding any other provision of law, Federal matching funds for training would be limited to the highest of:

—4 percent of the State's allotment for that fiscal year under Title XX funding ceiling,

—the actual amount of Federal matching for amounts spent by the State for training in fiscal year 1979, or

—the amount payable to the State with respect to State appropriations made prior to October 1, 1979 for fiscal year 1980, except that the additional amount would be limited to $6 million distributed among affected States.

Conference agreement.—The conference agreement provides that for fiscal years 1980 and 1981, the ceiling specified in the Senate bill would be in effect. For fiscal 1982 and thereafter, there would be no specific ceiling, but States would be reimbursed only for those expenditures included in an HEW approved State training plan, as in the House bill.

Use of Restricted Private Funds for Training Programs

(Sec. 204)

Present law.—Private funds donated to the State for purposes of meeting the non-Federal requirement for Title XX services or training must be donated without restrictions, unless the donor is not a sponsor or operator of a program that provides these services or training.

House bill.—No provision.

Senate bill.—The Senate bill provided that in fiscal year 1980, States would be permitted to accept restricted private matching funds for training purposes (except where the training was provided by a proprietary facility).

Conference agreement.—The House recedes with an amendment providing that States could accept restricted private matching funds in fiscal 1980 and fiscal 1981.

Emergency Shelter

(Sec. 205)

As in both the House and Senate bills, effective October 1, 1979, Title XX funds could be used for emergency shelter, for not in excess of 30 days in any 6 month period, as a protective service to an adult in danger of physical or mental injury, neglect, maltreatment, or exploitation.

Multi-Year Planning; Choice of Fiscal Year

(Sec. 206)

Present law.—Title XX requires States to develop annual service plans and to make them available for comment each year. The service plan year must coincide with the fiscal year of either the Federal or State Governments.

House bill.—The House bill provided that States would be given the option of using a 1, 2, or 3 year Title XX program period. States that opt for a multi-year program period would be required to make information about their plan available at such times as may be specified by HEW regulations.

Senate bill.—The Senate bill provided for multi-year planning as in the House bill and also provided that States would be given the option of using a service program period which coincides with the fiscal year used by local governments within the State.

Conference agreement.—Under the conference agreement, States would have the option of a multi-year Title XX program period, as in both bills, and a local government fiscal year, as in the Senate bill, effective for program periods beginning after enactment.

Social Services Funding for Territories

(Sec. 207)

As in both the House and Senate bills, a separate Title XX entitlement would be established for Puerto Rico, Guam, the Northern Marianas and the Virgin Islands in the following amounts, effective October 1, 1979:

	Millions
Puerto Rico	$15.0
Guam	.5
Virgin Islands	.5
Northern Marianas	.1
Total	16.1

Permanent Extension of Provisions Relating to Child Day Care Services and WIN Tax Credit

(Sec. 208)

Present law.—Employers of AFDC recipients who are placed in jobs under the WIN program, or who have received AFDC for at least 90 days, are eligible for a tax credit equal to 50% of up to $6,000 of wages per employee for the first year of employment and 25% of such wages for the second year.

House bill.—Present law.

Senate bill.—The Senate bill would permit employers who receive Title XX grants for purposes of hiring welfare recipients in child care jobs to elect to include such grants in wages eligible for the tax credit. For taxpayers who so elect, the credit amount would be limited so that the total amount of the credit plus the grant could not exceed the lesser of $6,000 or 100% of total wages paid to the employee. In addition, the bill would allow the tax credit for persons employed on a part-time basis in child care jobs and would make certain technical amendments to correct errors in the Revenue Act of 1978.

Conference agreement.—The conference agreement maintains the current law provision which provides that the credit is not allowed for wages reimbursed by a grant. The conference agreement provides, however, for a special 100-percent credit with respect to unreimbursed wages paid to workers whose wages are reimbursed in whole or in part by funds made available under section 2007 (grants to hire welfare recipients as child care workers) of the Social Security Act. If the taxpayer elects to compute the credit using this rate, the credit with respect to any employee is limited to the least of: (1) $6,000 minus the reimbursement with respect to this employee under section 2007, (2) $3,000 (for the first year of employment) or $1,500 (for the second year of employment), or (3) 50 percent (for the first year of employment) or 25 percent (for the second year of employment) of the sum of unreimbursed wages and the reimbursement under section 2007.

The conference agreement includes the Senate provision with regard to the eligibility of part-time child care workers for the credit. Regulations should define a minimum standard for part-time employment, such as 8 hours per week for the first 4 weeks of employment, to ensure that employees are eligible only if they have established a regular employment relationship with the employer.

Services to Alcoholics and Drug Addicts

(Sec. 209)

Both the House and Senate bills provided for making permanent a temporary provision of law which allows Title XX funds to be used for certain rehabilitative services provided to alcoholics and drug addicts, and for limited funding of detoxification services provided in medical facilities.

TITLE III—OTHER SOCIAL SECURITY ACT PROVISIONS

Federal Funding for Non-AFDC Child Support Enforcement Program

(Sec. 301)

Present law.—To cover administrative costs, Federal funds are available at a 75% matching rate for child support enforcement services provided to AFDC recipients. Matching funds were also available for non-AFDC families until September 30, 1978 under prior provisions of law and were extended to March 31, 1980 by P.L. 96–178. States are allowed to charge an application fee of no more than $20 to non-AFDC families and to recover costs in excess of the application fee by deducting such costs from the amount of child support collected.

House bill.—No provision.

Senate bill.—The Senate bill reinstated the provision for 75% Federal matching on a permanent basis.

Conference agreement.—The House recedes.

Incentive To Report Earnings Under AFDC Program

(Sec. 302)

Present law.—Present law provides no penalty for failure to make a timely report of earned income.

House bill.—No provision.

Senate bill.—The bill provided that the earnings disregards would not be applied to any earned income that is not reported on a timely basis (unless there is good cause).

Conference agreement.—The House recedes.

Prorating of Shelter Allowance

(Sec. 303)

Present law.—A State generally may not presume that the income of any nonlegally responsible relative is available to a child for purposes of AFDC.

House bill.—No provision.

Senate bill.—The Senate bill permitted a State to prorate the shelter and utilities portion of the AFDC benefit in the case of a child who is living with a relative who is not himself an AFDC recipient so as to take account of that relative's presumed contribution to those shelter costs. The provision applies where the relative is not legally responsible for the AFDC child's support, or where none of the legally responsible

relatives living with the child is eligible for AFDC because such relative is being supported by another person or another program and where the total income of the household equals or exceeds the State standard of need for a unit that size or the total income of the unit cannot be determined.

Conference agreement.—The House recedes.

Services for Disabled and Blind Children Receiving SSI

(Sec. 304)

Present law.—As a part of the SSI program, $30 million in Federal funds were authorized for allocation to States to provide services to blind and disabled children receiving SSI. This program expired September 30, 1979.

House bill.—No provision.

tive is being supported by another person or another program, and

Senate bill.—The Senate bill extended the program from October 1, 1979 until September 30, 1982.

Conference agreement.—The House recedes.

Public Assistance Payments to Territorial Jurisdictions

(Sec. 305)

As in both the House and Senate bills, the temporary $78 million funding level and 75 percent matching rate provided in fiscal 1979 for AFDC and assistance programs for the aged, blind and disabled in Puerto Rico, Guam and the Virgin Islands would be made permanent, effective October 1, 1979. (As of October 1, 1979, the funding level reverted to the permanent level of $26 million and the matching rate reverted to 50 percent.)

Period Within Which Certain Claims Must Be Filed

(Sec. 306)

Present law.—There is no time limit on State submission of claims under the public assistance, medicaid and social services programs in the Social Security Act.

House bill.—The bill provided that no payment may be made to a State with respect to any expenditure under the Child Welfare Services Program (Title IV–B of the Social Security Act) unless the Secretary received a claim for Federal reimbursement on or before the last day of the fiscal year following the fiscal year in which the expenditure is made.

Senate bill.—The bill provided that no payment may be made to a State with respect to any expenditure under the AFDC, Medicaid, Social Services, and other Social Security Act programs unless the Secretary received a claim for Federal reimbursement from the State within a two-year period after expenditure: except, court-ordered retroactive payments, audit exceptions, adjustments to prior year costs, or where the Secretary determines there is good cause to waive the limit. The provision would be effective starting with fiscal

year 1980 expenditures, except that the provision specified that there shall be no time limit on the payment of claims which have been filed prior to enactment and that claims for expenditures prior to fiscal year 1980 must be filed by December 31, 1980.

Conference agreement.—The House recedes.

Incentives for States To Collect Child Support Obligations

(Sec. 307)

Present law.—A 15 percent incentive payment financed entirely from the Federal share of collections is paid to States that enforce and collect support on behalf of other States, or to a political subdivision within a State that enforces or collects child support on behalf of its own State.

House bill.—No provision.

Senate bill.—The Senate bill retained provisions of present law, and, in addition, allowed States which enforce and collect child support within the State on their own behalf to receive the 15 percent incentive payment.

Conference agreement.—The House recedes.

Postponement of Imposition of Certain Penalties Relating to Child Support Requirements

(Sec. 309)

Present law.—If a State is found by an annual audit not to have an effective child support enforcement program which is effective and meets the requirements of Title IV–D, the State's AFDC reimbursement is reduced by 5 percent. (The first audit period was January 1 to September 30, 1977.)

House bill.—No provision.

Senate bill.—The Senate bill prohibited imposition of the 5 percent penalty for failure to have an effective child support enforcement program for the period January 1, 1977 to October 1, 1977 for any State which established its child support program on July 1, 1977.

Conference agreement.—The conference agreed that the 5 percent penalty for failure to have an effective child support enforcement program in current law would not be imposed on any State before October 1, 1980. The conferees note that this provision should not be considered to prejudice in any way the ultimate disposition of penalties for prior years.

Exchange of Information on Terminated or Suspended Providers Under Medicare and Medicaid Programs

(Sec. 308)

Present law.—The Secretary of HEW is required to suspend from the Medicare program any practitioner convicted of a criminal offense related to involvement in the program, and any institutional provider in which a managing employee has been so convicted, and to notify the

State Medicaid agency to suspend the physician or provider from the Medicaid program. Present law also allows the Secretary of HEW to exclude from the Medicare program individual practitioners or providers that knowingly or willfully make or cause to be made any false statements in an application for payment, or submit excessive bills, or furnish services in excess of needs. Federal matching payments may not be made under medicaid to any such suspended practitioner or provider.

House bill.—No provision.

Senate bill.—The Senate bill required the Secretary of HEW to notify the State Medicaid agency when individual practitioners or providers are suspended or terminated under the Medicare program for making false statements, submitting excessive bills, or furnishing services in excess of needs (but not necessarily convicted of a criminal offense). The bill also required the State Medicaid agency to promptly notify the Secretary of HEW whenever a provider of services or an individual practitioner is terminated, suspended or otherwise sanctioned or prohibited from participating under the Medicaid program.

Conference agreement.—The House recedes.

Continuation of Medicaid Eligibility for Certain Recipients of VA Pensions

(Sec. 310)

Present law.—Under P.L. 95–588, the Veterans' and Survivors' Pension Improvement Act of 1978, benefits were increased for recipients of non-service connected VA pensions, and pensioners were given the option to continue receiving their pensions under the pension system as in effect before enactment of the new law, or to elect to be covered under the new law.

Many pensioners are also eligible for and receive AFDC or SSI benefits. In all States except Arizona, a person who is an AFDC recipient is automatically eligible for Medicaid. In all but 15 States, eligibility for SSI also makes one categorically eligible for Medicaid. In the other 15 States a more restrictive standard is in use, but persons may be eligible if they spend their excess income on medical care.

Specific statutory language in SSI law requires, as a condition of eligibility, that any beneficiary apply for any other Federal benefits—such as higher VA pension benefits under the new pension law—to which he or she is entitled. Longstanding policy in the AFDC program has a similar result. Both AFDC and SSI count VA benefits as income in determining eligibility.

House bill.—No provision.

Senate bill.—The Senate bill allowed those AFDC and SSI recipients who were receiving VA pensions as of December, 1978, and who became eligible for the higher VA pension benefits under P.L. 95–588, and thereby became ineligible for Medicaid in those States which provide Medicaid eligibility for AFDC and SSI recipients only on a categorical basis, to disaffirm any entitlement to the higher VA pensions in order to continue eligibility for SSI, AFDC and Medicaid. (Medicaid eligibility would be restored retroactive to January, 1979.) It required that the Veterans' Administration keep separate records

of pensioners opting for the lower pension benefit and transfer the "savings" resulting therefrom to the Secretary of HEW in order to defray the cost to HEW and the States of the restored SSI, AFDC and Medicaid benefits.

Conference agreement.—The House recedes with an amendment. There would be no transfer of funds from the VA; and, individuals who have already lost eligibility for SSI or AFDC because of the higher VA pension would be considered to have remained eligible for SSI and AFDC for the months between their transfer to VA benefits and the date that this amendment becomes effective with respect to them.

PROVISIONS DELETED BY THE CONFERENCE

The conference did not accept:

1. The House provision that would have required States, prior to publication of their Title XX plan, to consult with local government officials.

2. The House provision that would have required States to specify in their Title XX plan the criteria for the distribution of Title XX funds within the State.

3. The House provision that would have added language to the Title XX law stating it was the purpose of the program to meet social service needs not otherwise being met.

4. The Senate provision that would have changed the earnings disregards under the AFDC program.

5. The Senate provision that would have required States, in determining AFDC eligibility or benefits, to take into account certain amounts of a stepparent's income.

6. The Senate provision that would have required States to have computerized medicaid management information systems operational by July 1, 1981.

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BOB DOLE,
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Finder's Aid

P.L. 96-398 (94 Stat, 1564) Approved October 7, 1980
Mental Health Systems Act

Subject	SS Act Section	P.L. Section	94 Stat.	H.Rep. 96-977	S.Rep. 96-712	S.C.Rep. 96-980
Mechanized Claims Processing and Information Retrieval Systems	1903(r)	901	1609	--	--	55, 64

BEST DOCUMENT AVAILABLE

MENTAL HEALTH SYSTEMS ACT

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Public Law 96-398
96th Congress

An Act

Oct. 7, 1980
[S. 1177]

To improve the provision of mental health services and otherwise promote mental health throughout the United States, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Mental Health Systems Act.
42 USC 9401 note.

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Mental Health Systems Act".

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Sec. 901. Mechanized claims processing and information retrieval systems.

FINDINGS

SEC. 2. The Congress finds— 42 USC 9401.

(1) despite the significant progress that has been made in making community mental health services available and in improving residential mental health facilities since the original community mental health centers legislation was enacted in 1963, unserved and underserved populations remain and there are certain groups in the population, such as chronically mentally ill individuals, children and youth, elderly individuals, racial and ethnic minorities, women, poor persons, and persons in rural areas, which often lack access to adequate private and public mental health services and support services;

(2) the process of transferring or diverting chronically mentally ill individuals from unwarranted or inappropriate institu-

CONTRACT AUTHORITY

SEC. 806. The authority of the Secretary to enter into contracts under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance by appropriation Acts. 42 USC 9523.

TITLE IX—MECHANIZED CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

MECHANIZED CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

SEC. 901. Section 1903 of the Social Security Act is amended by adding at the end thereof the following new subsection: 42 USC 1396b.

"(r)(1)(A) In order to receive payments under paragraphs (2) and (7) of subsection (a) without being subject to per centum reductions set forth in subparagraph (C) of this paragraph, a State must provide that mechanized claims processing and information retrieval systems of the type described in subsection (a)(3)(B) and detailed in an advance planning document approved by the Secretary are operational on or before the deadline established under subparagraph (B).

"(B) The deadline for operation of such systems for a State is the earlier of (i) September 30, 1982, or (ii) the last day of the sixth month following the date specified for operation of such systems in the State's most recently approved advance planning document submitted before the date of the enactment of this subsection.

"(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2) and (7) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning on or after such deadline, and shall be further reduced by an additional 5 percentage points after each period consisting of two quarters during which the Secretary determines the State fails to meet the requirements of subparagraph (A); except that—

"(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph; and

"(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State meets the requirements of subparagraph (A).

"(2)(A) In order to receive payments under paragraphs (2) and (7) of subsection (a) without being subject to the per centum reductions set forth in subparagraph (C) of this paragraph, a State must have its mechanized claims processing and information retrieval systems, of the type required to be operational under paragraph (1), initially approved by the Secretary in accordance with paragraph (5)(A) on or before the deadline established under subparagraph (B).

"(B) The deadline for approval of such systems for a State is the last day of the fourth quarter that begins after the date on which the Secretary determines that such systems became operational as required under paragraph (1).

"(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2) and (7) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning after such deadline, and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters during which the State fails to meet the requirements of subparagraph (A); except that—

"(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph, and

"(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State's systems are approved by the Secretary as provided in subparagraph (A).

"(D) Any State's systems which are approved by the Secretary for purposes of subsection (a)(3)(B) on or before the date of the enactment of this subsection shall be deemed to be initially approved for purposes of this subsection.

"(3)(A) When a State's systems are initially approved, the 75 per centum Federal matching provided in subsection (a)(3)(B) shall become effective with respect to such systems, retroactive to the first quarter beginning after the date on which such systems became operational as required under paragraph (1), except as provided in subparagraph (B).

Percentum reductions.

"(B) In the case of any State which was subject to a per centum reduction under paragraph (2), the per centum specified in subsection (a)(3)(B) shall be reduced by 5 percentage points for the first two quarters beginning after the deadline established under paragraph (2)(B), and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters beginning after such deadline and before the date on which such systems are initially approved, except that no reduction shall be made under this paragraph for any quarter following the quarter during which the State's systems are initially approved by the Secretary.

Approved systems, review.

"(4)(A) The Secretary shall review all approved systems not less often than once each fiscal year, and shall reapprove or disapprove any such systems. Systems which fail to meet the current performance standards, system requirements, and any other conditions for approval developed by the Secretary under paragraph (6) shall be disapproved. Any State having systems which are so disapproved shall be subject to a per centum reduction under subparagraph (B). The Secretary shall make the determination of reapproval or disapproval and so notify the States not later than the end of the first quarter following the review period.

"(B) If the Secretary disapproves a State's systems under subparagraph (A), the Secretary shall, with respect to such State for quarters beginning after the determination of disapproval and before the first quarter beginning after such systems are reapproved, reduce the per centum specified in subsection (a)(3)(B) to a per centum of not less than 50 per centum and not more than 70 per centum as the Secretary determines to be appropriate and commensurate with the nature of noncompliance by such State; except that such per centum may not be reduced by more than 10 percentage points in any 4-quarter period by reason of this subparagraph. No State shall be subject to a per centum reduction under this paragraph (i) before the fifth quarter beginning after such State's systems were initially approved, or (ii) on the basis of a review conducted before October 1, 1981.

Waiver.

"(C) The Secretary may retroactively waive a per centum reduction imposed under subparagraph (B), if the Secretary determines that the State's systems meet all current performance standards and other requirements for reapproval and that such action would improve the administration of the State's plan under this title, except that no such waiver may extend beyond the four quarters immediately prior to the quarter in which the State's systems are reapproved.

"(5)(A) In order to be initially approved by the Secretary, mechanized claims processing and information retrieval systems must be of

the type described in subsection (a)(3)(B) and must meet the following requirements:

"(i) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

"(ii) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's medicaid fraud control unit (if any) certified under subsection (q) of this section.

"(iii) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary under paragraph (6).

"(B) In order to be reapproved by the Secretary, mechanized claims processing and information retrieval systems must meet the requirements of subparagraphs (A)(i) and (A)(ii) and performance standards and other requirements for reapproval developed by the Secretary under paragraph (6).

"(6) The Secretary, with respect to State systems, shall— Functions.

"(A) develop performance standards, system requirements, and other conditions for approval for use in initially approving such State systems, and shall further develop written approval procedures for conducting reviews for initial approval, including specific criteria for assessing systems in operation to insure that all such performance standards and other requirements are met; Performance standards, development.

"(B) by not later than October 1, 1980, develop an initial set of performance standards, system requirements, and other conditions for reapproval for use in reapproving or disapproving State systems, and shall further develop written reapproval procedures for conducting reviews for reapproval, including specific criteria for reassessing systems operations over a period of at least six months during each fiscal year to insure that all such performance standards and other requirements are met on a continuous basis;

"(C) provide that reviews for reapproval, conducted before October 1, 1981, shall be for the purpose of developing a systems performance data base and assisting States to improve their systems, and that no per centum reduction shall be made under paragraph (4) on the basis of such a review; Systems performance data base, development.

"(D) insure that review procedures, performance standards, and other requirements developed under subparagraph (B) are sufficiently flexible to allow for differing administrative needs among the States, and that such procedures, standards, and requirements are of a nature which will permit their use by the States for self-evaluation;

"(E) notify all States of proposed procedures, standards, and other requirements at least one quarter prior to the fiscal year in which such procedures, standards, and other requirements will be used for conducting reviews for reapproval;

"(F) periodically update the systems performance standards, system requirements, review criteria, objectives, regulations, and guides as the Secretary shall from time to time deem appropriate;

"(G) provide technical assistance to States in the development and improvement of the systems so as to continually improve the capacity of such systems to effectively detect cases of fraud or abuse; Technical assistance to States.

"(H) for the purpose of insuring compatibility between the State systems and the systems utilized in the administration of title XVIII—

42 USC 1395. Coding system, development.

"(i) develop a uniform identification coding system (to the extent feasible) for providers, other persons receiving payments under the State plans (approved under this title) or under title XVIII, and beneficiaries of medical services under such plans or title;

Liaison between States, carriers and intermediaries.

"(ii) provide liaison between States and carriers and intermediaries having agreements under title XVIII to facilitate timely exchange of appropriate data; and

"(iii) improve the exchange of data between the States and the Secretary with respect to providers and other persons who have been terminated, suspended, or otherwise sanctioned under a State plan (approved under this title) or under title XVIII;

Reasonable costs, definitions.

"(I) develop and disseminate clear definitions of those types of reasonable costs relating to State systems which are reimbursable under the provisions of subsection (a)(3) of this section; and

Report to Congress.

"(J) report on or before October 1, 1981, to the Congress on the extent to which States have developed and operated effective mechanized claims processing and information retrieval systems.

Waiver.

"(7)(A) The Secretary shall waive the provisions of this subsection with respect to initial operation and approval of mechanized claims processing and information retrieval systems with respect to any State which--

"(i) had a 1976 population (as reported by the Bureau of the Census) of less than 1,000,000 and which made total expenditures (including Federal reimbursement) for which Federal financial participation is authorized under this title of less than $100,000,000 in fiscal year 1976 (as reported by such State for such year), or

"(ii) is a Commonwealth, or territory or possession, of the United States,

if such State reasonably demonstrates, and the Secretary does not formally disagree, that the application of such provisions would not significantly improve the efficiency of the administration of such State's plan under this title.

Timetable

"(B) If the Secretary determines that the application of the provisions described in subparagraph (A) to a State would significantly improve the efficiency of the administration of the State's plan under this title, the Secretary may withdraw the State's waiver under subparagraph (A) and, in such case, the Secretary shall impose a timetable for such State with respect to compliance with the provisions of this subsection and the imposition of per centum reductions. Such timetable shall be comparable to the timetable established under this subsection as to the amount of time allowed such State to comply and the timing of per centum reductions.

"(8)(A) The per centum reductions provided for under this subsection shall not apply to a State for any quarter with respect to which the Secretary determines that such State is unable to comply with the relevant requirements of this subsection—

"(i) for good cause (but such a waiver may not be for a period in excess of 2 quarters), or

"(ii) due to circumstances beyond the control of such State.

Report to Congress.

"(B) If the Secretary determines under subparagraph (A) that such a reduction will not apply to a State, the Secretary shall report to the

Congress on the basis for each such determination and on the modification of all time limitations and deadlines as described in subparagraph (C).

"(C) For purposes of determining all time limitations and deadlines imposed under this subsection, any time period during which a State was found under subparagraph (A)(ii) to be unable to comply with requirements of this subsection due to circumstances beyond its control shall not be taken into account, and the Secretary shall modify all such time limitations and deadlines with respect to such State accordingly.".

Time limitations and deadlines, modification.

Approved October 7, 1980.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 96-977 accompanying H.R. 7299 (Comm. on Interstate and Foreign Commerce) and No. 96-1367 (Comm. of Conference).
SENATE REPORTS: No. 96-712 (Comm. on Labor and Human Resources) and No. 96-980 (Comm. of Conference).
CONGRESSIONAL RECORD, Vol. 126 (1980):
July 24, considered and passed Senate.
Aug. 22, H.R. 7299 considered and passed House; passage vacated and S. 1177, amended, passed in lieu.
Sept. 24, Senate agreed to conference report.
Sept. 30, House agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 16, No. 41:
Oct. 7, Presidential statement.

96TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
No. 96-977

MENTAL HEALTH SYSTEMS ACT

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

together with

DISSENTING VIEWS

[To accompany H.R. 7299]

[Including cost estimate of the Congressional Budget Office]

MAY 15, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON: 1980

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No material re social security in this report.

Calendar No. 762

96TH CONGRESS
2d Session

SENATE

REPORT
No. 96-712

THE MENTAL HEALTH SYSTEMS ACT

REPORT

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

TO ACCOMPANY

S. 1177

MAY 15 (legislative day, JANUARY 3), 1980.—Ordered to be printed

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WASHINGTON : 1980

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No material re social security in this report.

96TH CONGRESS
2d Session

SENATE

REPORT
No. 96-980

MENTAL HEALTH SYSTEMS ACT

SEPTEMBER 23 (legislative day, JUNE 12), 1980.—Ordered to be printed

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Mr. ROBERT C. BYRD (for Mr. KENNEDY), from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany S. 1177]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 1177) to improve the provision of mental health services and otherwise promote mental health throughout the United States, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Mental Health Systems Act".

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Sec. 107. Allotments to States to improve the administration of State mental health programs.

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Sec. 203. Grants for services for severely mentally disturbed children and adolescents.
Sec. 204. Grants for mental health services for elderly individuals and other priority populations.
Sec. 205. Grants for non-revenue-producing services.
Sec. 206. Grants for mental health services in health care centers.
Sec. 207. Grants and contracts for innovative projects.
Sec. 208. Grants for the prevention of mental illness and the promotion of mental health.

TITLE III—GENERAL PROVISIONS RESPECTING GRANT PROGRAMS

PART A—STATE MENTAL HEALTH SERVICE PROGRAMS

Sec. 301. State mental health services programs.
Sec. 302. Contents of programs.
Sec. 303. Mental health provisions of State health plans.

PART B—APPLICATIONS AND RELATED PROVISIONS

Sec. 305. State administration.
Sec. 306. Processing of applications by State mental health authorities.
Sec. 307. Applications.
Sec. 308. Indian tribes and organizations.
Sec. 309. Procedures.

PART C—PERFORMANCE

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PART D—ENFORCEMENT

Sec. 321. Enforcement.

PART E—MISCELLANEOUS

Sec. 325. National Institute of Mental Health Prevention Unit.
Sec. 326. Technical assistance.
Sec. 327. Indirect provision of services.
Sec. 328. Cooperative agreements.

TITLE IV—ASSOCIATE DIRECTOR FOR MINORITY CONCERNS

Sec. 401. Associate Director for Minority Concerns.

TITLE V—MENTAL HEALTH RIGHTS AND ADVOCACY

Sec. 501. Bill of rights.
Sec. 502. Grants for protection and advocacy programs.

TITLE VI—RAPE PREVENTION AND CONTROL

Sec. 601. Rape prevention and control.
Sec. 602. Grants for services for rape victims.

TITLE VII—EXTENSION OF COMMUNITY MENTAL HEALTH CENTERS ACT

Sec. 701. One-year extension of Community Mental Health Centers Act.

TITLE VIII—MISCELLANEOUS

Sec. 801. Employee protection.
Sec. 802. Report on shelter and basic living needs of chronically mentally ill individuals.
Sec. 803. Obligated service for mental health traineeships.
Sec. 804. Conforming amendments.
Sec. 805. Special pay for Public Health Service physicians and dentists.
Sec. 806. Contract authority.

TITLE IX—MECHANIZED CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

Sec. 901. Mechanized claims processing and information retrieval systems.

FINDINGS

SEC. 2. The Congress finds—

(1) despite the significant progress that has been made in making community mental health services available and in improving residential mental health facilities since the original community mental health centers legislation was enacted in 1963, unserved and underserved populations remain and there are certain groups in the population, such as chronically mentally ill individuals, children and youth, elderly individuals, racial and ethnic minorities, women, poor persons, and persons in rural areas, which often lack access to adequate private and public mental health services and support services;

(2) the process of transferring or diverting chronically mentally ill individuals from unwarranted or inappropriate institutionalized settings to their home communities has frequently not been accompanied by a process of providing those individuals with the mental health and support services they need in community-based settings;

(3) the shift in emphasis from institutional care to community-based care has not always been accompanied by a process of affording training, retraining, and job placement for employees affected by institutional closure and conversion;

(4) the delivery of mental health and support services is typically uncoordinated within and among local, State, and Federal entities;

(5) mentally ill persons are often inadequately served by (A) programs of the Department of Health and Human Services such as medicare, medicaid, supplemental security income, and social services, and (B) programs of the Department of Housing and Urban Development, the Department of Labor, and other Federal agencies;

(6) health care systems often lack general health care personnel with adequate mental health care training and often lack mental health care personnel and consequently many individuals with some level of mental disorder do not receive appropriate mental health care;

(7) present knowledge of methods to prevent mental illness through discovery and elimination of its causes and through early detection and treatment is too limited;

(8) a comprehensive and coordinated array of appropriate private and public mental health and support services for all people in need within specific geographic areas, based upon a

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 1777), an act to improve the provision of mental health services and otherwise promote mental health throughout the United States, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The House amendment to the text of the bill struck out all of the Senate bill after the enacting clause and inserted a substitute text.

The Senate recedes from its disagreement to the amendment of the House with an amendment which is a substitute for the Senate bill and the House amendment. The differences between the Senate bill, the House amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the Conferees, and minor drafting and clarifying changes.

FINDINGS AND PURPOSE

The Senate bill included findings and purposes.

The House amendment did not include findings or purposes.

The Conference substitute conforms generally to the findings of the Senate bill.

DEFINITIONS

The Senate bill contained definitions.

The House amendment contained some definitions not in the Senate bill.

The Conference substitute includes most definitions from the Senate bill and the House amendment, with some modifications.

STATE MENTAL HEALTH SYSTEMS

The Senate bill required as a condition of funding under the Act that each State meet several requirements regarding its mental health system, including the designation of State mental health authorities and mental health service areas, the inclusion in State health plans of mental health provisions, and the preparation of mental health operations programs; an enforcement provision was also included.

The House amendment contained similar provisions except that no additions were made to the State health plan.

The Conference substitute conforms generally to the Senate bill.

MEDICAID MANAGEMENT INFORMATION SYSTEM

The Senate bill required States to establish a mechanized claims processing and information retrieval system.

The House amendment contained no similar provision.

The Conference substitute conforms to the Senate bill.

TITLE

The House recedes from its amendment to the title of the bill.

EDWARD KENNEDY,
HARRISON A. WILLIAMS, Jr.,
CLAIBORNE PELL,
GAYLORD NELSON,
ALAN CRANSTON,
HOWARD M. METZENBAUM,
DICK SCHWEIKER,
JACOB JAVITS,
ORRIN HATCH,
ROBT. STAFFORD,
Managers on the Part of the Senate.

HARLEY O. STAGGERS,
HENRY A. WAXMAN,
RICHARDSON PREYER,
ANDY MAGUIRE,
TOM LUKEN,
DOUG WALGREN,
BARBARA A. MIKULSKI,
JAMES T. BROYHILL,
TIM LEE CARTER,
SAM DEVINE,
DAVE STOCKMAN,
Managers on the Part of the House.

Finder's Aid

P.L. 96-403 (94 Stat. 1709) Approved October 9, 1980
Reallocation of Social Security Taxes Between OASI and DI Trust Funds

Subject	SS Act Section	P.L. Section	94 Stat.	H.Rep. 96-1148	S.Rep. 96-946
Reallocation of Funds Between OASI and DI Trust Funds	201(b)(1)	1(a)	1709	1-8	1-5
Reallocation of Funds Between OASI and DI Trust Funds	201(b)(2)	1(b)	1709	1-8	1-5

BEST DOCUMENT AVAILABLE

Public Law 96-403
96th Congress

An Act

To amend title II of the Social Security Act to make necessary adjustments in the allocation of social security tax receipts between the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund.

Oct. 9, 1980
[H.R. 7670]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 201(b)(1) of the Social Security Act is amended by striking out clauses (H) through (K) and inserting in lieu thereof the following: "(H) 1.50 per centum of the wages (as so defined) paid after December 31, 1978, and before January 1, 1980, and so reported, (I) 1.12 per centum of the wages (as so defined) paid after December 31, 1979, and before January 1, 1981, and so reported, (J) 1.30 per centum of the wages (as so defined) paid after December 31, 1980, and before January 1, 1982, and so reported, (K) 1.65 per centum of the wages (as so defined) paid after December 31, 1981, and before January 1, 1985, and so reported, (L) 1.99 per centum of the wages (as so defined) paid after December 31, 1984, and before January 1, 1990, and so reported, and (M) 2.20 per centum of the wages (as so defined) paid after December 31, 1989, and so reported,".

Social security tax receipts, allocation.
42 USC 401.

(b) Section 201(b)(2) of such Act is amended by striking out clauses (H) through (K) and inserting in lieu thereof the following: "(H) 1.0400 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1978, and before January 1, 1980, (I) 0.7775 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1979, and before January 1, 1981, (J) 0.9750 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1980, and before January 1, 1982, (K) 1.2375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1981, and before January 1, 1985, (L) 1.4250 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1984, and before January 1, 1990, and (M) 1.6500 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1989,".

42 USC 401 note.

SEC. 2. The amendments made by the first section of this Act shall apply with respect to remuneration paid, and taxable years beginning, after December 31, 1979.

Approved October 9, 1980.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 96-1148 (Comm. on Ways and Means).
SENATE REPORT No. 96-946 (Comm. on Finance).
CONGRESSIONAL RECORD, Vol. 126 (1980):
July 21, considered and passed House.
Sept. 25, considered and passed Senate.

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96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 96-1148

REALLOCATION OF SOCIAL SECURITY TAXES BETWEEN OASI AND DI TRUST FUNDS

JULY 2, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany H.R. 7670]

The Committee on Ways and Means, to whom was referred the bill (H.R. 7670) to amend title II of the Social Security Act to make necessary adjustments in the allocation of social security tax receipts between the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

BACKGROUND INFORMATION AND GENERAL EXPLANATION OF THE BILL

The Social Security Act provides for the creation of three separate trust funds into which payroll tax receipts are automatically appropriated. These are the Old Age and Survivors Insurance (OASI) Trust Fund, the Disability Insurance (DI) Trust Fund, and the Hospital Insurance (HI) Trust Fund.

H.R. 7670 addresses the cash flow problem facing the OASI trust fund.

Under present law tax allocation rates, which were established by the Social Security Amendments of 1977, reserves in the OASI fund are expected to be insufficient to meet benefit payments toward the end of calendar year 1981. This is the result of sharp changes in economic conditions as compared to the economic assumptions that were made in 1977. Much higher increases in living costs have been experienced and are predicted for the next few years.

Reserves in the DI fund, however, are expected to increase steadily in the future under both the intermediate and pessimistic assumptions of the 1980 Trustees report. The more favorable condition of the DI trust fund is the result of the recent enactment of Public Law 96–265, the Disability Amendments of 1980, and the current experience of the DI program which has been more favorable than predicted at the time of the 1977 Amendments.

Reallocation has been the traditional way of redistributing the OASDI tax rates because of changes in the law and in the experience of the program. Your Committee's bill would provide for such a reallocation between the OASI and DI funds for two years only, 1980 and 1981. This is expected to maintain sufficient reserves in the OASI fund to pay benefits for approximately an additional year, from late 1981 to late 1982, under the Trustees' intermediate assumptions, giving Congress additional time to take further remedial action.

The bill would not change the total social security tax rates for any one year.

A comparison of the allocation rates for the OASI and DI Trust Funds, expressed in terms of the rates applicable to taxes paid by employers, employees and self-employed individuals, under present law and under H.R. 7670 is contained in table 1.

Table 2 indicates the estimated reserve ratios in the OASI and DI trust funds, separately and combined, under present law and under H.R. 7670, according to the three sets of economic assumptions expressed in the 1980 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Disability Insurance Trust Funds.

TABLE 1.—REAOLLOCATION OF TAX RATE SCHEDULE BETWEEN OASI AND DI UNDER H.R. 7670

[Percent of taxable earnings]

Calendar years	Total for OASDI [1]	Allocated rates under present law		Reallocated rates under H.R. 7670	
		OASI	DI	OASI	DI
Employees and employers, each:					
1980	5.08	4.330	0.750	4.520	0.560
1981	5.35	4.525	.825	4.700	.650
1982–84	5.40	4.575	.825	4.575	.825
1985–89	5.70	4.750	.950	4.750	.950
1990 and later	6.20	5.100	1.100	5.100	1.100
Self-employed persons:					
1980	7.05	6.0100	1.0400	6.2725	.7775
1981	8.00	6.7625	1.2375	7.0250	.9750
1982–84	8.05	6.8125	1.2375	6.8125	1.2375
1985–89	8.55	7.1250	1.4250	7.1250	1.4250
1990 and later	9.30	7.6500	1.6500	7.6500	1.6500

[1] The total OASDI tax rate under H.R. 7670 between OASI and DI is the same as under present law.

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TABLE 2.—TRUST FUND ASSETS AT THE BEGINNING OF THE YEAR AS A PERCENTAGE OF OUTGO DURING THE YEAR UNDER PRESENT LAW AND UNDER H.R. 7670

UNDER PRESENT LAW

	Optimistic assumptions			Intermediate assumptions			Pessimistic assumptions		
	OASI	DI	OASDI	OASI	DI	OASDI	OASI	DI	OASDI
1979	30	30	30	30	30	30	30	30	30
1980	23	36	24	23	35	24	23	35	24
1981	15	45	19	15	44	18	14	43	18
1982	8	65	15	6	61	12	3	55	9
1983	2	92	12	−2	84	8	−9	70	(1)
1984	−4	126	11	−10	111	4	−21	88	−8
1985	−8	169	11	−17	142	(1)	−33	109	−17
1986	−7	239	19	−21	196	3	−42	149	−21
1987	−4	320	30	−23	254	7	−52	192	−25
1988	(1)	406	42	−26	315	11	−62	236	−30
1989	5	498	55	−27	378	16	−73	283	−34
1990	11	594	70	−28	442	23	−83	332	−38
UNDER H.R. 7670									
1979	30	30	30	30	30	30	30	30	30
1980	23	36	24	23	35	24	23	35	24
1981	19	21	19	18	20	18	18	19	18
1982	14	16	15	12	13	12	9	10	9
1983	8	40	12	4	33	8	−3	23	(1)
1984	3	73	11	−3	60	4	−15	43	−8
1985	−1	113	11	−11	91	1	−27	64	−17
1986	(1)	181	19	−14	144	3	−36	103	−21
1987	3	260	30	−17	201	7	−46	146	−25
1988	7	344	41	−19	261	11	−56	191	−29
1989	12	434	55	−21	324	16	−67	238	−34
1990	18	528	70	−21	388	23	−77	286	−38

Other Matters to be Discussed Under the Rules of the House

1. In compliance with clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the vote by your committee on the motion to report the bill. The motion to report the bill was adopted by voice vote.

2. In compliance with clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the oversight findings by your committee. As a result of your committee's oversight activities with respect to the allocation of social security tax receipts between the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, your committee has concluded that it is necessary and appropriate to reallocate these tax receipts between the respective Trust Funds in the manner provided in the bill.

3. In compliance with clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, your committee states that no oversight findings or recommendations have been submitted to your committee by the Committee on Government Operations with respect to the subject matter contained in the bill.

4. In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the following statement is made relative to the costs incurred in carrying out this bill. The bill makes no change in the total social security tax rates for any year. The bill will provide for a reallocation, for two years (1980 and 1981) only, of existing tax receipts between the Old-Age and Survivors Trust Fund and the Disability Insurance Trust Fund. Accordingly, your committee reports no costs related to the provisions of this bill.

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5. In compliance with clause 2(1)(4) of rule XI of the Rules of the House of Representatives, your committee states that the enactment of the bill H.R. 7679 will not have any inflationary impact on prices and costs in the operation of the national economy.

6. In compliance with clause 2(1)(3)(B) of rule XI of the Rules of the House of Representatives, your committee advises that the bill provides no new budget authority or new or increased tax expenditures.

7. In compliance with clause 2(1)(3)(C) of rule XI of the Rules of the House of Representatives, your committee advises that the Congressional Budget Office reports no costs associated with enactment of H.R. 7670.

Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Section 201 of the Social Security Act

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * * * *

FEDERAL OLD-AGE AND SURVIVORS INSURANCE TRUST FUND AND FEDERAL DISABILITY INSURANCE TRUST FUND

Section 201. (a) * * *

(b) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Disability Insurance Trust Fund". The Federal Disability Insurance Trust Fund shall consist of such gifts and bequests as may be made as provided in subsection (i)(1), and of such amounts as may be appropriated to, or deposited in, such fund as provided in this section. There is hereby appropriated to the Federal Disability Insurance Trust Fund for the fiscal year ending June 30, 1957, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1)(A) ½ of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1956, and before January 1, 1966, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, (B) 0.70 of 1 per centum of the wages (as so defined) paid after December 31, 1965, and before January 1, 1968, and so reported, and (C) 0.95 of 1 per centum of the wages (as so defined) paid after December 31, 1967, and before January 1, 1970, and so reported, (D) 1.10 per centum of the wages (as so defined) paid after December 31, 1969, and before January 1, 1973, and so reported, (E) 1.1 per centum of the wages (as so defined) paid after December 31, 1972, and before January 1, 1974, and so reported, (F) 1.15 per centum of the wages (as so defined) paid after December 31, 1973,

and before January 1, 1978, and so reported, (G) 1.55 per centum of the wages (as so defined) paid after December 31, 1977, and before January 1, 1979, and so reported, [(H) 1.50 per centum of the wages (as so defined) paid after December 31, 1978, and before January 1, 1981, and so reported, (I) 1.65 per centum of the wages (as so defined) paid after December 31, 1980, and before January 1, 1985, and so reported, (J) 1.90 per centum of the wages (as so defined) paid after December 31, 1984, and before January 1, 1990, and so reported, and (K) 2.20 per centum of the wages (as so defined) paid after December 31, 1989, and so reported.] *(H) 1.50 per centum of the wages (as so defined) paid after December 31, 1978, and before January 1, 1980, and so reported, (I) 1.12 per centum of the wages (as so defined) paid after December 31, 1979, and before January 1, 1981, and so reported, (J) 1.30 per centum of the wages (as so defined) paid after December 31, 1980, and before January 1, 1982, and so reported, (K) 1.65 per centum of the wages (as so defined) paid after December 31, 1981, and before January 1, 1985, and so reported, (L) 1.90 per centum of the wages (as so defined) paid after December 31, 1984, and before January 1, 1990, and so reported, and (M) 2.20 per centum of the wages (as so defined) paid after December 31, 1989, and so reported,*

(2)(A) ⅜ of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1956, and before January 1, 1966, (B) and 0.525 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1965, and before January 1, 1968, and (C) 0.7125 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1967, and before January 1, 1970, (D) 0.825 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1969, and before January 1, 1973, (E) 0.795 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1972, and before January 1, 1974, (F) 0.815 of 1 per centum of the amount of self-employment income (as so defined) as reported for any taxable year beginning after December 31, 1973, and before January 1, 1978, (G) 1.090 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1977, and before January 1, 1979, [(H) 1.0400 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1978, and before January 1, 1981, (I) 1.2375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1980, and before January 1, 1985, (J) 1.4250 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1984, and before January 1, 1990, and (K) 1.650 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1989,] *(H) 1.0400 per centum of the amount of self-employment income (as so defined) so reported*

for any taxable year beginning after December 31, 1978, and before January 1, 1980, (I) 0.7775 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1979, and before January 1, 1981, (J) 0.9750 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1980, and before January 1, 1982, (K) 1.2375 per centum if the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1981, and before January 1, 1985, (L) 1.4250 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1984, and before January 1, 1990, and (M) 1.6500 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1989,

* * * * * * *

ADDITIONAL VIEWS OF THE HONORABLE BARBER B. CONABLE, JR., BILL FRENZEL, JOHN H. ROUSSELOT, AND W. HENSON MOORE ON H.R. 7670

Unless some action is taken, the Old Age and Survivors Insurance (OASI) Trust Fund will not have enough money to pay benefits through 1981. This bill, which temporarily would shift payroll tax collections from the Disability Insurance (DI) Trust Fund to OASI, represents the least we can do to prevent a breadkown in the social security system next year.

It buys us a little time—a *very* little time. Current actuarial projections indicate that this reallocation between OASI and DI will postpone the next social security "day of reckoning" from the fall of 1981 to the late summer or fall of 1982.

Because something should be done now to assure that benefit payments will be made at least through next year, we do not oppose this bill.

But we deplore the continued disposition of the Congress to take *ad hoc* action to cure the structural ills of the social security system.

About 35 million persons are receiving social security benefits now and more than 114 million contributors are paying those benefits. No other Federal program or set of programs affect so many of our citizens.

These people are becoming fed-up with the failure of the Congress to put the system on a sounder, longer-range financial footing. With aggravating frequency, they are reading and hearing that the trust funds are going bankrupt, that there won't be any money left when it's their turn to draw benefits.

The Congress has been reacting to these periodic alarums by patching just enough to keep the machine running for another year or so, or until the next election has passed. There were assertions in 1977 that lasting solutions were provided in the Amendments of that year, but some of us were not fooled by that rhetoric and said so. Financing to last 25 years actually lasted three.

The central point is that public patience is running out, and so is the capacity of the Congress to continue reliance on short-term answers. There are persistent problems related to the system's treatment of women, its coverage of virtually every worker in the country except government employees, its built-in tilt toward welfare and its weakened insurance character. There also is the awesome demographic spectre. The post-war baby boom is moving through the population like a pig through a python, and shortly after the turn of the century each beneficiary may be supported by the contributions of just two workers.

All of these difficulties are hovering, waiting to be overcome. They will not go away. They will become more pressing.

There are many ways we can make the social security system solvent over a long period of time, and thus reassure its understandably nervous participants. Some were suggested in Republican alternatives to the 1977 Amendments, but we are not exclusively tied to any single approach. We are, however, anxious to get moving.

We fervently hope this is the last time we have to put our finger in the dike. We are buying some time, so let's use it.

JOHN H. ROUSSELOT.
W. HENSON MOORE.
BARBER B. CONABLE, Jr.
BILL FRENZEL.

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Calendar No. 1036

96TH CONGRESS
2d Session

SENATE

REPORT
No. 96-946

REALLOCATION OF SOCIAL SECURITY TAXES BETWEEN OASI AND DI TRUST FUNDS

SEPTEMBER 16 (legislative day, JUNE 12), 1980.—Ordered to be printed

Mr. LONG, from the Committee on Finance, submitted the following

REPORT

[To accompany H.R. 7670]

The Committee on Finance, to which was referred the bill (H.R. 7670) to amend title II of the Social Security Act to make necessary adjustments in the allocation of social security tax receipts between the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

The optimum level of reserve in the social security trust funds has generally been considered to be an amount equal to approximately 1 year's benefit payments.

I. BACKGROUND INFORMATION AND GENERAL EXPLANATION OF THE BILL

The Social Security Act provides for the creation of three separate trust funds into which payroll tax receipts are automatically appropriated. These are the Old Age and Survivors Insurance (OASI) Trust Fund, the Disability Insurance (DI) Trust Fund, and the Hospital Insurance (HI) Trust Fund.

Under present law, tax allocation rates, which were established by the Social Security Amendments of 1977, reserves in the OASI fund are expected to be insufficient to meet benefit payments before the end of calendar year 1981. This is the result of sharp changes in economic conditions as compared to the economic assumptions that were made in 1977. Much higher increases in living costs have been experienced and are predicted for the next few years.

Reserves in the DI fund, however, are expected to increase steadily in the future under both the intermediate and pessimistic assumptions of the 1980 Trustees report. The more favorable condition of the DI trust fund is the result of the recent enactment of Public Law 96–265, the Disability Amendments of 1980, and the current experience of the DI program which has been more favorable than predicted at the time of the 1977 Amendments.

Reallocation has been the traditional way of redistributing the OASDI tax rates because of changes in benefit provisions and in the experience of the program. The Committee bill would provide for such a reallocation between the OASI and DI funds for two years only, 1980 and 1981. This is expected to maintain sufficient reserves in the OASI fund to pay benefits through the end of 1981, giving Congress time to take further remedial action next year.

The bill would not change the total social security tax rates for any year.

A comparison of the allocation rates for the OASI and DI Trust Funds, expressed in terms of the rates applicable to taxes paid by employers, employees and self-employed individuals, under present law and under H.R. 7670 is contained in table 1.

Table 2 indicates the estimated reserve ratios in the OASI and DI trust funds, separately and combined, under present law and under H.R. 7670, according to the economic assumptions used for the July 1980 midsession budget review.

TABLE 1.—REALLOCATION OF TAX RATE SCHEDULE BETWEEN OASI AND DI UNDER H.R. 7670

[Percent of taxable earnings]

Calendar years	Total for OASDI [1]	Allocated rates under present law		Reallocated rates under H.R. 7670	
		OASI	DI	OASI	DI
Employees and employers, each:					
1980	5.08	4.330	0.750	4.520	0.560
1981	5.35	4.525	.825	4.700	.650
Self-employed persons:					
1980	7.05	6.0100	1.0400	6.2725	.7775
1981	8.00	6.7625	1.2375	7.0250	.9750

[1] The total OASDI tax rate under H.R. 7670 between OASI and DI is the same as under present law.

TABLE 2.—END-OF-YEAR CASH BENEFIT FUND BALANCES

[As a percent of following year outgo]

Year	Present law			H.R. 7670		
	OASI	DI	Combined funds	OASI	DI	Combined funds
1980	14	43	17	17	19	17
1981	4	58	10	10	11	10

II. Budgetary and Regulatory Impact

The bill relates solely to the allocation among accounts maintained in the Treasury for social security taxes which will be collected under existing law. It does not modify the tax laws or the substantive provisions of the social security program in any manner. H.R. 7670 is

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therefore not expected to have any budgetary or regulatory impact of the type required to be discussed under the Standing Rules of the Senate or the Congressional Budget Act.

III. Vote of the Committee to Report the Bill

In compliance with paragraph 3 of rule XXVI of the Standing Rules of the Senate, the following statement is made relative to the vote of the Committee to report the bill: The bill was ordered reported by a voice vote.

IV. Changes in Existing Law Made by the Bill

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic type, existing law in which no change is proposed is printed in roman type):

Section 201 of the Social Security Act

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * * * *

FEDERAL OLD-AGE AND SURVIVORS INSURANCE TRUST FUND AND FEDERAL DISABILITY INSURANCE TRUST FUND

Section 201.(a) * * *

(b) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Disability Insurance Trust Fund". The Federal Disability Insurance Trust Fund shall consist of such gifts and bequests as may be made as provided in subsection (i)(1), and of such amounts as may be appropriated to, deposited in, such fund as provided in this section. There is hereby appropriated to the Federal Disability Insurance Trust Fund for the fiscal year ending June 30, 1957, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1)(A) ½ of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1956, and before January 1, 1966, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, (B) 0.70 of 1 per centum of the wages (as so defined) paid after December 31, 1965, and before January 1, 1968, and so reported, and (C) 0.95 of 1 per centum of the wages (as so defined) paid after December 31, 1967, and before January 1, 1970, and so reported, (D) 1.10 per centum of the wages (as so defined) paid after December 31, 1969, and before January 1, 1973, and so reported, (E) 1.1 per centum of the wages (as so defined) paid after December 31, 1972, and before January 1, 1974, and so reported, (F) 1.15 per centum of the wages (as so defined) paid after December 31, 1973, and before

January 1, 1978, and so reported, (G) 1.55 per centum of the wages (as so defined) paid after December 31, 1977, and before January 1, 1979, and so reported [(H) 1.50 per centum of the wages (as so defined) paid after December 31, 1978, and before January 1, 1981, and so reported, (I) 1.65 per centum of the wages (as so defined) paid after December 31, 1980, and before January 1, 1985, and so reported, (J) 1.90 per centum of the wages (as so defined) paid after December 31, 1984, and before January 1, 1990, and so reported, and (K) 2.20 per centum of the wages (as so defined) paid after December 31, 1989, and so reported.] *(H) 1.50 per centum of the wages (as so defined) paid after December 31, 1978, and before January 1, 1980, and so reported, (I) 1.12 per centum of the wages (as so defined) paid after December 31, 1979, and before January 1, 1981, and so reported, (J) 1.30 per centum of the wages (as so defined) paid after December 31, 1980, and before January 1, 1982, and so reported, (K) 1.65 per centum of the wages (as so defined) paid after December 31, 1981, and before January 1, 1985, and so reported, (L) 1.90 per centum of the wages (as so defined) paid after December 31, 1984, and before January 1, 1990, and so reported, and (M) 2.20 per centum of the wages (as so defined) paid after December 31, 1989, and so reported,*

(2)(A) ⅜ of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1956, and before January 1, 1966, (B) and 0.525 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1965, and before January 1, 1968, and (C) 0.7125 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1967, and before January 1, 1970, (D) 0.825 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1969, and before January 1, 1973, (E) 0.795 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1972, and before January 1, 1974, (F) 0.815 of 1 per centum of the amount of self-employment income (as so defined) as reported for any taxable year beginning after December 31, 1973, and before January 1, 1978, (G) 1.090 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1977, and before January 1, 1979, [(H) 1.0400 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1978, and before January 1, 1981, (I) 1.2375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1980, and before January 1, 1985; (J) 1.4250 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1984, and before January 1, 1990, and (K) 1.650 per centum of the amount of self-employment income (as so defined)

so reported for any taxable year beginning after December 31, 1989,] *(H) 1.0400 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1978, and before January 1, 1980, (I) 0.7775 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1979, and before January 1, 1981, (J) 0.9750 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1980, and before January 1, 1982, (K) 1.2375 per centum if the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1981, and before January 1, 1985, (L) 1.4250 per centum of the amount of self-employment income (as ao defined) so reported for any taxable year beginning after December 31, 1984, and before January 1, 1990, and (M) 1.6500 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1989,*

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Finder's Aid 541

P.L. 96-473 (94 Stat. 2263) Approved October 19, 1980
Retirement Test

Subject	SS Act Section	P.L. Section	94 Stat.	H.Rep. 96-537 Part 1	H. Rep. 96-537 Part 2	S. Rep. 96-987
Payment to Prisoners	202(d)(7)(A)	5(b)	2265	—	—	2, 7-9
Technical Amendment	202(e)(2)(B)(1)	6(a)	2265	—	—	—
Technical Amendment	203(a)(3)(A)	6(b)(1)	2265	—	—	—
Technical Amendment	203(a)(7)	6(b)(2)	2265	—	—	—
Technical Amendment	203(f)(1)(D)	1(a)(1)(A)	2263	—	—	—
Retroactive Effect of Elimination of Monthly Earnings Test	203(f)(1)(E)	4(a)	2264	2-7	2	1-5
Monthly Exception Applies to Year Entitlement Ends	203(f)(1)(F)	1(a)(1)(B)	2263	2-7	2	2-3
Technical Amendment	203(f)(2)	1(a)(2)	2263	—	—	—
Income Not Attributed to Services After Entitlement	203(f)(5)(D)	3(a)	2264	2-7	2	4-5
Technical Amendment	213(a)(2)(A)	6(c)	2265	—	—	—
Technical Amendment	215(a)(4)(B)	6(d)	2265	—	—	—
Technical Amendment	216(i)(1)	5(a)(2)	2265	—	—	—
Limits on Benefits for Prisoners	223(d)(6)	5(a)(1)	2264	—	—	7-9
Suspension of Benefits for Prisoners	223(f)	5(c)	2265	—	—	7-9
Medicare Entitlement	226(a)(2)	2(a)	2263	3-5	2	3-4 12
Technical Amendment	303(d)(sic)	6(e)(1)	2265	—	—	—
Technical Amendment	304(a)(2)	6(e)(2)	2265-2266	—	—	—
Technical Amendment	402(a)(27)	6(f)(1)	2266	—	—	—
Technical Amendment	402(a)(29)	6(f)(2)	2266	—	—	—
Technical Amendment	402(d)(sic)	6(f)(3)	2266	—	—	—
Technical Amendment	1612(a)(1)(B)	6(g)(1)	2266	—	—	—
Technical Amendment	1612(a)(1)(C) (sic)	6(g)(2)(B)	2266	—	—	—
Technical Amendment	1612(b)(2)(B)	6(g)(3)(A)	2266	—	—	—
Technical Amendment	1631(b)	6(h)(1)	2266	—	—	—
Technical Amendment	1631(b)(2)(sic)	6(h)(2)	2266	—	—	—
Technical Amendment	1811(1)	2(b)	2263	—	—	—
Technical Amendment	1815(c)	6(i)	2266	—	—	—
Technical Amendment	1833(g)(sic)	6(j)	2266	—	—	—
Technical Amendment	1905(c)	6(k)	2266	—	—	—
Technical Amendment	2003(e)(1)	6(l)	2266	—	—	—

BEST DOCUMENT AVAILABLE

Public Law 96-473
96th Congress

An Act

To amend the Social Security Act with respect to the retirement test, to reduce spending under title II of the Social Security Act, and for other purposes.

Oct. 19, 1980
[H.R. 5295]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Social Security Act, amendment.

PROVISION RELATING TO AVAILABILITY OF MONTHLY EARNINGS TEST

SECTION 1. (a)(1) Section 203(f)(1) of the Social Security Act is amended— 42 USC 403.

(A) by striking out "or" immediately before clause (E), and

(B) by inserting before the period at the end thereof the following: ", or (F) in which such individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than the applicable exempt amount as determined under paragraph (8), in the case of an individual entitled to benefits under section 202(b) (but only by reason of having a child in her care within the meaning of paragraph (1)(B) of that subsection) or under section 202 (d) or (g), if such month is in a year in which such entitlement ends for a reason other than the death of such individual, and such individual is not entitled to any benefits under this title for the month following the month during which such entitlement under section 202 (b), (d), or (g) ended". 42 USC 402.

(2) Section 203(f)(2) of such Act is amended by striking out "(D), and (E)" and inserting in lieu thereof "(D), (E), and (F)".

(b) The amendments made by subsection (a) shall apply with respect to monthly benefits payable for months after December 1977. 42 USC 403 note.

MEDICARE ENTITLEMENT

SEC. 2. (a) Section 226(a)(2) of the Social Security Act is amended by inserting after "section 202" the following: ", or would be entitled to those benefits except that he has not filed an application therefor (or application has not been made for a benefit the entitlement to which for any individual is a condition of entitlement therefor) and, in conformity with regulations of the Secretary, files an application for hospital insurance benefits under part A of title XVIII,". 42 USC 426.

(b) Section 1811(1) of such Act is amended by striking out "are entitled to" and inserting in lieu thereof "are eligible for". 42 USC 1395c. 42 USC 1395c.

(c) For purposes of section 226 of such Act as amended by subsection (a) of this section, an individual who filed an application for monthly insurance benefits under section 202 of such Act prior to the effective date of the amendment made by subsection (a) shall be deemed to have filed an application for hospital insurance benefits under part A of title XVIII of such Act, at the time he applied for such benefits under section 202 regardless of the continuing status or effect of the application for benefits under section 202, if he would have been 42 USC 426 note. 42 USC 402.

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entitled to benefits under that section had such application remained in effect.

42 USC 426 note. (d) The amendments made by subsections (a) and (b) shall be effective after the second month beginning after the date on which this Act is enacted.

INCOME NOT ATTRIBUTABLE TO SERVICES PERFORMED AFTER ENTITLEMENT

42 USC 403. SEC. 3. (a) Section 203(f)(5)(D) of the Social Security Act is amended to read as follows:

"(D) In the case of—

"(i) an individual who has attained the age of 65 on or before the last day of the taxable year, and who shows to the satisfaction of the Secretary that he or she is receiving royalties attributable to a copyright or patent obtained before the taxable year in which he or she attained such age and that the property to which the copyright or patent relates was created by his or her own personal efforts, or

"(ii) an individual who has become entitled to insurance benefits under this title, other than benefits under section 223 or benefits payable under section 202(d) by reason of being under a disability, and who shows to the satisfaction of the Secretary that he or she is receiving, in a year after his or her initial year of entitlement to such benefits, any other income not attributable to services performed after the month in which he or she initially became entitled to such benefits,

42 USC 423, 402.

there shall be excluded from gross income any such royalties or other income.".

42 USC 403 note. (b) The amendment made by subsection (a) shall apply with respect to taxable years ending after December 31, 1977, but only with respect to benefits payable for months after December 1977.

RETROSPECTIVE EFFECT OF ELIMINATION OF MONTHLY EARNINGS TEST

42 USC 403. SEC. 4. (a) Section 203(f)(1) of the Social Security Act is amended by striking out "the first month" in clause (E) and inserting in lieu thereof "the first month after December 1977".

42 USC 403 note. (b) The amendment made by subsection (a) shall apply with respect to monthly benefits payable for months after December 1977.

BENEFITS FOR CERTAIN PRISONERS

42 USC 423. SEC. 5. (a)(1) Section 223(d) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(6)(A) Notwithstanding any other provision of this title, any physical or mental impairment which arises in connection with the commission by an individual (after the date of the enactment of this paragraph) of an offense which constitutes a felony under applicable law and for which such individual is subsequently convicted, or which is aggravated in connection with such an offense (but only to the extent so aggravated), shall not be considered in determining whether an individual is under a disability.

"(B) Notwithstanding any other provision of this title, any physical or mental impairment which arises in connection with an individual's confinement in a jail, prison, or other penal institution or correctional facility pursuant to such individual's conviction of an

offense (committed after the date of the enactment of this paragraph) constituting a felony under applicable law, or which is aggravated in connection with such a confinement (but only to the extent so aggravated), shall not be considered in determining whether such individual is under a disability for purposes of benefits payable for any month during which such individual is so confined.".

(2) The third sentence of section 216(i)(1) of such Act is amended by striking out "and (5)" and inserting in lieu thereof "(5), and (6)". 42 USC 416.

(b) Section 202(d)(7)(A) of such Act is amended by adding at the end thereof the following: "An individual shall not be considered a 'full-time student' for the purpose of this section while that individual is confined in a jail, prison, or other penal institution or correctional facility, pursuant to his conviction of an offense (committed after the date of the enactment of this paragraph) which constituted a felony under applicable law.". "Fulltime student." 42 USC 402.

(c) Section 223 of such Act is amended by adding at the end thereof the following new subsection: 42 USC 423.

"Suspension of Benefits for Inmates of Penal Institutions

"(f)(1) Notwithstanding any other provision of this title, no monthly benefits shall be paid under this section, or under section 202(d) by reason of being under a disability, to any individual for any month during which such individual is confined in a jail, prison, or other penal institution or correctional facility, pursuant to his conviction of an offense which constituted a felony under applicable law, unless such individual is actively and satisfactorily participating in a rehabilitation program which has been specifically approved for such individual by a court of law and, as determined by the Secretary, is expected to result in such individual being able to engage in substantial gainful activity upon release and within a reasonable time.

"(2) Benefits which would be payable to any individual (other than a confined individual to whom benefits are not payable by reason of paragraph (1)) under this title on the basis of the wages and self-employment income of such a confined individual but for the provisions of paragraph (1), shall be payable as though such confined individual were receiving such benefits under this section.".

(d) The amendments made by this section shall be effective with respect to benefits payable for months beginning on or after October 1, 1980. 42 USC 402 note.

TECHNICAL CORRECTIONS

SEC. 6. (a) Section 202(e)(2)(B)(i) of such Act is amended by striking out the second comma following "where applicable". 42 USC 402.

(b)(1) Section 203(a)(3)(A) of such Act is amended by striking out "bases" and inserting in lieu thereof "basis". 42 USC 403.

(2) Section 203(a)(7) of such Act is amended by striking out "benefits base" and inserting in lieu thereof "benefit base".

(c) Section 213(a)(2)(A) of such Act is amended by striking out "quarters of coverage" and inserting in lieu thereof "quarter of coverage". 42 USC 413.

(d) Section 215(a)(4)(B) of such Act is amended by striking out "computation or recommendation" and inserting in lieu thereof "computation or recomputation". 42 USC 415.

(e)(1) Section 303 of such Act is amended by redesignating the second subsection (d) as subsection (e). *Ante*, p. 468.

(2) Section 304(a)(2) of such Act is amended to read as follows: 42 USC 504.

"(2) makes a finding with respect to a State under subsection (b), (c), (d), or (e) of section 303,".

42 USC 503.

42 USC 602.

(f)(1) Section 402(a)(27) of such Act is amended by striking out "provide, that the State" and inserting in lieu thereof "provide that the State".

(2) Section 402(a)(29) of such Act is amended by striking out "provided" and inserting in lieu thereof "provide".

(3) Section 402 of such Act is amended by redesignating the second subsection (d) as subsection (e).

Ante, p. 449.

(g)(1) Section 1612(a)(1)(B) of such Act is amended by striking out "following subsection (a)(10)" and inserting in lieu thereof "following subsection (a)(11)".

(2) Section 1612(a)(1) of such Act is further amended—

(A) by striking out "and" at the end of subparagraph (B); and

(B) by redesignating the second subparagraph (C) as subparagraph (D).

42 USC 1382a.

(3) Section 1612(b)(2)(B) of such Act is amended—

(A) by striking out "Monthly" and inserting in lieu thereof "monthly"; and

(B) by striking out the period at the end thereof and inserting in lieu thereof a semicolon.

Ante, p. 470.

(h) Section 1631(b) of such Act is amended—

(1) by striking out "(b)(1)(1)" and inserting in lieu thereof "(b)(1)"; and

(2) by redesignating the second paragraph (2) as paragraph (3).

42 USC 1395g.

(i) Section 1815(c) of such Act is amended by striking out "for on in connection with" and inserting in lieu thereof "for or in connection with".

42 USC 1395*l*.

(j) Section 1833 of such Act is amended by redesignating the second subsection (g) as subsection (h).

42 USC 1396d.

(k) Section 1905(c) of such Act is amended by striking out "under clauses (1)" and inserting in lieu thereof "under clause (1)".

42 USC 1397b.

(l) Section 2003(e)(1) of such Act is amended by striking out "under subsection (g)" and inserting in lieu thereof "under subsection (d)".

Approved October 19, 1980.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 96-537, Pts. 1 and 2 (Comm. on Ways and Means).
SENATE REPORT No. 96-987 (Comm. on Finance).
CONGRESSIONAL RECORD:
Vol. 125 (1979): Dec. 19, considered and passed House.
Vol. 126 (1980): Sept. 30, considered and passed Senate, amended.
Oct. 1, House concurred in Senate amendments with an amendment; Senate concurred in House amendment.

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BEST DOCUMENT AVAILABLE

96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 96-537

EARNINGS TEST FOR SOCIAL SECURITY BENEFICIARIES

OCTOBER 19, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 5295]

[Including Cost Estimate and Comparison of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 5295) to amend title II of the Social Security Act to make the monthly earnings test available in limited circumstances in the case of certain beneficiaries, to amend the technical requirements for entitlement to medicare, and to provide that income attributable to services performed before an individual first becomes entitled to old-age insurance benefits shall not be taken into account (after 1977) in determining his or her gross income for purposes of the earnings test, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment (stated in terms of the page and line numbers of the introduced bill) is as follows:

Page 4, after line 20, insert the following new section:

> SEC. 4. (a) Section 203(f)(1) of the Social Security Act is amended by striking out "the first month" in clause (E) and insert in lieu thereof "the first month after December 1977".
>
> (b) The amendment made by subsection (a) shall apply with respect to monthly benefits payable for months after December 1977.

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I. Principal Purposes of the Bill

H.R. 5295 is in the nature of remedial legislation, designed to correct certain problems with the social security earnings limitation that have arisen since enactment of Public Law 95–216, the Social Security Amendments of 1977.

The 1977 amendments eliminated the monthly earnings test (which included the substantial services test for the self-employed) and placed the earnings limitation on a strictly annual dollar test, except for the first year of retirement.

It has become evident to your committee that several categories of beneficiaries were experiencing problems with the new annual test. Certain beneficiaries, such as mother's and children's beneficiaries and workers entitled to medicare, have run into unintended difficulties with the new provision. The repeal of the monthly measure also eliminated the substantial services test for the self-employed, which has laid bare the issue of how to treat income attributable to preretirement services under the annual earnings limitation. Finally, many individuals were adversely affected by an administrative interpretation of the broad language in the new annual test which essentially gives retrospective effect to the provision limiting beneficiaries to a single monthly earnings test year.

II. Summary of Provisions

A. RESTORE THE MONTHLY EARNINGS TEST IN THE YEAR BENEFITS END FOR CERTAIN CLASSES OF BENEFICIARY

Individuals receiving child's (including student's) benefits, mother's benefits, or father's benefits would have the use of the monthly earnings test in the year in which they cease to be entitled to such benefits.

Effective date: Would apply with respect to monthly benefits payable for months after December 1977.

B. PROVIDE FOR SEPARATE APPLICATIONS FOR TITLE II AND MEDICARE BENEFITS

Individual would be allowed to file separately for hospital insurance benefits without applying for title II benefits.

Effective date: After the second month beginning after the date of enactment. Applications filed prior to this date would be deemed to have been filed separately.

C. EXCLUDE FROM THE EARNINGS TEST INCOME ATTRIBUTABLE TO SERVICES RENDERED BEFORE RETIREMENT

Income attributable to services performed before an individual first becomes entitled to old-age insurance benefits would not be taken into account in determining his or her gross income for purposes of the earnings test.

Effective date: Would apply with respect to months after December 1977.

D. ALLOW ALL BENEFICIARIES THE USE OF THE MONTHLY EARNINGS TEST IN AT LEAST ONE YEAR AFTER 1977

All beneficiaries would have the use of the monthly earnings test in the first year after 1977 in which they are entitled to a benefit and have a month in which they earn less than one-twelfth of the annual exempt amount in wages and do not perform substantial services in self-employment.

Effective date: Would apply with respect to monthly benefits payable for months after December 1977.

III. General Discussion

An earnings test, used to determine whether a loss of earnings has occurred, has always been a part of the social security program. Before 1978, the earnings test consisted of an annual test and a monthly test. Under the test, benefits were reduced by $1 for every $2 of earnings over the annual exempt amount, except that regardless of the amount of annual earnings, there was no reduction for any month the beneficiary did not earn over one-twelfth the annual exempt amount or perform substantial services in self-employment.

The Congress, in the Social Security Amendments of 1977, Public Law 95–216, replaced the monthly test, except for 1 "grace year" with a strictly annual earnings test. The purpose of this change was to simplify the test and to end the differential treatment of people who had similar amounts of annual earnings but differences in their monthly work patterns after retirement.

As enacted, Public Law 95–216 provided that a person would be entitled to use the monthly earnings test only in a year in which the person first receives social security benefits of a particular type (without having received benefits of any other type in the preceding month) and in which there is a month the person does not earn over one-twelfth the annual exempt amount or perform substantial services in self-employment. The purpose of providing the monthly test for this "grace year," generally the initial year of retirement, was to

assure that a person who retired after earning a substantial amount in the year of retirement would get benefits for the month the beneficiary actually was retired. This provision was effective for benefits payable after December 1977.

Your committee has noted with concern that several unintended problems have arisen as a result of the elimination of the monthly test and social security beneficiaries have been adversely affected. The bill reported by your committee would alleviate these problems as follows:

A. RESTORE THE MONTHLY EARNINGS TEST FOR THE YEAR THAT CHILD'S, MOTHER'S, OR FATHER'S BENEFITS ARE TERMINATED

Your committee has found that elimination of the monthly test is unduly harsh on beneficiaries entitled to child's (including student's) benefits or mother's (or father's) benefits in the year their benefits terminate and they go to work. Generally, these beneficiaries are likely to enter the work force and have substantial earnings in the year their benefits end. If these earnings are over the annual exempt amount, the benefits they already received in the year can become overpayments and have to be repaid. This occurs because the monthly test is not available to them, so that their earnings after benefits end can result in reduction of benefits due them earlier in the year. Frequently, these beneficiaries do not know at the beginning of the year whether they will have earnings later in the year. Requiring them to repay social security benefits received earlier in the year discourages them from working.

Your committee's bill would allow these beneficiaries the use of the monthly earnings test in the year their benefits end. This provision would not prevent a person from receiving a "grace year" when he later becomes entitled to a social security benefit as a disabled or retired worker. The change would be retroactive to January 1978 so that beneficiaries in these categories who lost benefits as a result of the 1977 amendments would have the benefits restored.

B. PROVIDE FOR SEPARATE APPLICATIONS FOR SOCIAL SECURITY CASH BENEFITS AND MEDICARE BENEFITS

Under social security law, in order for a person to be entitled to social security hospital insurance benefits at age 65, that person must file for social security cash benefits even though benefits would be withheld because the individuals earnings are too high. As a result, a person's "grace year" can be inadvertently triggered by an isolated month of no earnings or low earnings. Then, upon actual retirement from work in a later year, the monthly test is not available and the person might not receive any social security benefits until the following year.

Your committee's bill would provide for separate applications for cash benefits for the nondisabled and for hospital insurance benefits in order to reserve the "grace year" for the year the person actually retires. The bill would provide that people who have already withdrawn their applications for cash and medicare benefits and repaid the cash and medicare benefits received in order to reserve their "grace year" for another year would be deemed to have filed an application

for medicare benefits as of the date the original application for cash and medicare benefits was filed. The provision of the bill would not impair the authority of the Secretary of HEW with respect to the retroactive payment of medicare benefits in the case of people whose previously withdrawn applications for medicare benefits are reinstated.

C. EXCLUDE SELF-EMPLOYMENT INCOME ATTRIBUTABLE TO SERVICES RENDERED BEFORE ENTITLEMENT FROM THE EARNINGS TEST

The conversion to an annual test for all years except the year of retirement has brought into focus the definitional issue of how certain kinds of income earnings received by self-employed beneficiaries should be treated for retirement test purposes. As a result of the combined annual-monthly earnings test in effect prior to 1978, a self-employed beneficiary could receive a benefit for any month in which he did not render substantial services in self-employment, even if annual earnings were substantial. The primary test used to determine whether an individual had engaged in substantial services was whether he worked over 45 hours a month in self-employment. As a result, while the monthly earnings test was in effect, certain self-employed beneficiaries receiving income based on services rendered before retirement could receive 12 months of social security benefits so long as they did not breach the substantial services test. When the 1977 amendments eliminated the monthly substantial services test, however, the characterization of this income as earned or unearned became crucial and immediate.

Several categories of self-employed workers and retirees were adversly affected by the repeal of the monthly earnings test in 1978. Particularly affected are self-employed special and general insurance agents. Many of these agents sell insurance policies on which they receive renewal commissions—commissions that in many instances were long planned for use as retirement income. Under applicable tax law, income from the commissions is counted as income for social security and Federal income tax purposes in the year in which the income is received. But, as long as the monthly test was in effect, the agents could receive 12 months of social security benefits since the test for self-employed beneficiaries under substantial services test was 45 hours of work or less per month. With the monthly earnings test repealed, many of these agents lose some or all of their social security benefits when their commission income is substantial.

Similarly affected by the repeal of the monthly test are certain retired partners such as lawyers and accountants. The substantial services test had application to those beneficiaries who had retired from the partnership and were receiving a return of the capital (equity or debt) or work-in-progress payments they had invested in the partnership. (This is to be distinguished from retired partners receiving payments from a partnership under a qualified plan where the partner's share of capital has been fully returned. These cases are governed by section 211(a)(9) of the act.) Under the monthly earnings test prior to 1978, partners receiving such payments could also receive full social security benefits for any month in which they did not perform substantial services in self-employment. With elimination of the substantial services test the payments to the retired partner result in many cases in reductions or complete withholding of benefits.

Another group of self-employed beneficiaries affected by the 1977 amendment is farmers. Prior law permitted farmers to sell a crop in a year after the year of retirement without having that income cause a loss of social security benefits for any month so long as the farmer did not perform substantial services in self-employment in any month of the year in which the crop was sold. Now that the substantial services test is limited to the year of retirement, income from a later year sale of a crop raised in the year of retirement or a year prior to retirement can affect a retired farmer's benefits under the annual earnings limitation, whether or not he performs substantial services in the year of the sale.

Your committee's bill would provide that deferred income of both employees and the self-employed would be treated substantially the same for the purposes of the earnings test, that is, income attributable to services rendered prior to entitlement would not be included in gross income for earnings test purposes. This provision would be made retroactive to the effective date of the 1977 amendment and benefits would be recomputed for persons who lost benefits as a result of deferred self-employment income being included under the annual earnings test.

D. PROVIDE FOR PROSPECTIVE APPLICATION OF THE ELIMINATION OF THE MONTHLY EARNINGS TEST

The retrospective application of the elimination of the monthly earnings test has generated a significant amount of criticism. No clear guidance can be discerned from the committee reports of floor debate on the question of prospective or retrospective application. The cost estimates the administration gave the Congress during the 1977 deliberations, as well as the estimates included in the fiscal year 1978 budget submitted by the President, implicitly assumed retrospective application.

The Social Security Administration has proceeded with a retrospective application. Applying the provision retrospectively means that any person who filed a valid application for cash benefits and had one or more months of earnings below the monthly exempt amount before January 1978 is deemed to have already used the monthly test year. This reduces benefits paid to many individuals who have drawn benefits in the past but had not yet retired. They would lose benefits in the year they actually do retire as a consequence of having filed for benefits prior to 1978. Retrospective application of the provision caught many beneficiaries unaware and without adequate opportunity to make personal retirement decisions necessary to meet the effects of the change to an annual earnings test.

The retrospective implementation of the "grace year" provision has adversely affected about 265 thousand beneficiaries who received benefits because of the monthly test for one or more months before 1978 and can result in financial hardship. For example, a beneficiary who has used his grace year may retire in the middle of a year, but receive no benefits for the rest of the year because of his earnings for the first 6 months.

The problems that have resulted from the retrospective implementation of the provision were heightened because the 1977 amendments were signed into law on December 20, 1977 only a few days before the

new earnings test provision became effective on January 1. The Social Security Administration was unable to provide its field offices with revised operating instructions until after the legislation had been reviewed and all questions regarding implementation had been resolved. This delay caused some people to be paid benefits in early 1978 based on prior law; they then were overpaid when the new law was implemented.

Your committee provides in the bill for the prospective application of the elimination of the monthly earnings test, that is, all beneficiaries would have the use of the monthly earnings test in at least one year after 1977. As a result, people who lost social security benefits under the retrospective implementation would have their benefits restored.

IV. Cost Estimates for the OASDI System

TABLE 1.—OASDI COST ESTIMATES FOR H.R. 5295 TO MODIFY THE RETIREMENT TEST, FISCAL YEARS 1980–84

[Dollar amounts in millions]

Retirement test proposal	Effective Jan. 1—	Additional OASDI benefit payments in fiscal years 1980–84				
		1980[1]	1981	1982	1983	1984
H.R. 5295:						
1. Exclude all self-employment deferred income prior to entitlement	1978	$67	$33	$35	$39	$43
2. For persons receiving mother's or child's benefits, provide for application of monthly measure in year in which entitlement to such benefits is terminated; also provide that an individual applying for medicare at age 65 does not also have to apply for retirement benefits at the same time	1978	20	27	32	38	43
3. For all beneficiaries, provide for application of monthly measure in the first year after 1977 in which a "non-work" month occurs	1978	229	13	2	(2)	(2)
Total for H.R. 5295		316	73	69	77	86

[1] Payments in 1980 include all additional benefits for months prior to 1980.
[2] Less than $500,000.

Notes: 1. The above estimates are based on the intermediate assumptions in the 1979 trustees report, modified to reflect the actual benefit increase of 9.9 percent for June 1979. 2. The enactment of each bill was assumed to be in 1979.

TABLE 2.—OASDI COST ESTIMATES FOR H.R. 5295 TO MODIFY THE RETIREMENT TEST, CALENDAR YEARS 1980–84

[Dollar amounts in millions]

Retirement test proposal	Effective Jan. 1—	Additional OASDI benefit payments in calendar years 1980–84				
		1980[1]	1981	1982	1983	1984
H.R. 5295:						
1. Exclude all self-employment deferred income prior to entitlement	1978	$75	$34	$36	$40	$44
2. For persons receiving mother's or child's benefits, provide for application of monthly measure in year in which entitlement to such benefits is terminated; also provide that an individual applying for medicare at age 65 does not also have to apply for retirement benefits at the same time	1978	25	28	32	39	44
3. For all beneficiaries, provide for application of monthly measure in the first year after 1977 in which a "non-work" month occurs	1978	234	10	(2)	(2)	(2)
Total for H.R. 5295		334	72	68	79	88

[1] Payments in 1980 include all additional benefits for months prior to 1980.
[2] Less than $500,000.

Notes: 1. The above estimates are based on the intermediate assumptions in the 1979 trustees report, modified to reflect the actual benefit increase of 9.9 percent for June 1979. 2. The enactment of each bill was assumed to be in 1979.

BEST DOCUMENT AVAILABLE

96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPT. 96-537
1st Session } { Part 2

EARNINGS TEST FOR SOCIAL SECURITY BENEFICIARIES

DECEMBER 12, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

SUPPLEMENTAL REPORT

[To accompany H.R. 5295]

The purpose of this supplemental report is to provide an additional year of estimates of the costs which would be incurred in carrying out the provisions of H.R. 5295.

Clause 7(a)(1) of rule XIII of the Rules of the House of Representatives requires that cost estimates be shown in the committee report for the fiscal year in which the bill is reported and in each of the immediately following 5 years. The committee's report on H.R. 5295 (H. Rept. 96-537), filed on October 19, 1979, inadvertently omitted the estimates for the fifth fiscal year, that is, 1985. This supplemental report is designed to supply this omission.

The cost estimates of the Social Security Administration in table 1 on page 7 of the committee's report, in which cost estimates the committee concurs, are corrected to read as follows:

TABLE 1.—OASDI COST ESTIMATES FOR H.R. 5295 TO MODIFY THE RETIREMENT TEST, FISCAL YEARS 1980-84

[Dollar amounts in millions]

Retirement test proposal	Effective Jan. 1—	Additional OASDI benefit payments in fiscal years 1980–84					
		[1] 1980	1981	1982	1983	1984	1985
H.R. 5295:							
1. Exclude all self-employment deferred income prior to entitlement	1978	$67	$33	$35	$39	$43	$47
2. For persons receiving mother's or child's benefits, provide for application of monthly measure in year in which entitlement to such benefits is terminated; also provide that an individual applying for medicare at age 65 does not also have to apply for retirement benefits at the same time	1978	20	27	32	38	43	49
3. For all beneficiaries, provide for application of monthly measure in the first year after 1977 in which a "non-work" month occurs	1978	229	13	2	(2)	(2)	(2)
Total for H.R. 5295		316	73	69	77	86	96

[1] Payments in 1980 include all additional benefits prior to 1980.
[2] Less than $500,000.

Notes: 1. The above estimates on the intermediate assumptions in the 1979 trustees report, modified to reflect the actual benefit increase of 9.9 percent for June 1979. 2. The enactment of each bill was assumed to be in 1979.

In addition, paragraphs numbered 5 and 6 in the cost estimates of the Congressional Budget Office on page 10 of the committee's report are corrected to read as follows:

5. Cost estimate:

Estimated cost to the Federal Government

	Millions
Estimated budget authority:	
Fiscal year:	
1980	—$11
1981	—25
1982	—33
1983	—41
1984	—50
1985	—60
Estimated outlays:	
Fiscal year:	
1980	311
1981	69
1982	68
1983	81
1984	95
1985	110

6. Basis for estimate: The following table summarizes the expected cost of each provision. CBO concurs with the administration's estimates of the recipient population affected by these provisions, and of the first year administrative costs or savings of their implementation. CBO has, however, adjusted the costs for these groups to reflect CBO economic assumptions.

TABLE 1.—ESTIMATED COST TO OASI TRUST FUNDS RESULTING FROM PROVISIONS OF H.R. 5295

[By fiscal years, in millions of dollars]

	1980	1981	1982	1983	1984	1985
Provides monthly earnings test in year they leave the rolls for mothers of young children and for students	17	21	25	31	36	41
Separate medicare application	—5	1	4	8	11	14
Exclusion of deferred income	67	34	37	42	48	55
Allowance of at least 1 full earnings test year	232	13	2			
Total cost	311	69	68	81	95	110

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Calendar No. 1097

96TH CONGRESS 2d Session } SENATE { REPORT No. 96-987

AMENDMENTS TO THE SOCIAL SECURITY PROGRAM

SEPTEMBER 24 (legislative day, JUNE 12), 1980.—Ordered to be printed

Mr. LONG, from the Committee on Finance, submitted the following

REPORT

[To accompany H.R. 5295]

The Committee on Finance, to which was referred the bill (H.R. 5295) to amend title II of the Social Security Act to make the monthly earnings test available in limited circumstances in the case of certain beneficiaries, to amend the technical requirements for entitlement to medicare, and to provide that income attributable to services performed before an individual first becomes entitled to old-age insurance benefits shall not be taken into account (after 1977) in determining his or her gross income for purposes of the earnings test, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill as amended do pass.

I. Summary

Monthly exception to the retirement test.—A provision of the Social Security Amendments of 1977 eliminated the previously applicable monthly exception to the social security retirement test. Under the prior law, a social security beneficiary could receive full benefits for any month of the year in which he engaged in little or no work activity even if benefits would otherwise not be payable under the annual retirement test provision. The 1977 amendments deleted this monthly exception other than as it applies in the first year in which an individual becomes entitled to some payment under it. The change made by the 1977 amendments had a number of apparently unintended effects which would be corrected by the committee bill. Specifically, the committee bill would allow the monthly exception in the year in which entitlement ends to child's benefits or to benefits as a wife or widow with a child in care (unless entitlement ends by reason of death or by reason of entitlement to another type of social security benefit). The

committee bill also provides for a separate application to establish medicare eligibility without inadvertently triggering the one "grace year" in which the monthly exception is permitted. Another element of the Committee bill would allow the exclusion from income for retirement test purposes of self-employment income which is not based on services by the beneficiary subsequent to his initial month of entitlement. This would apply after the initial year of entitlement. In addition, the committee bill would allow all beneficiaries to qualify for at least one "grace year" in which the monthly exception applies after 1977 even though they may have used the monthly exception in 1977 or some prior year.

Reallocation of OASDI taxes.—The committee bill provides for a reallocation of the 1980 and 1981 collections of the social security cash benefit tax into the two trust funds it supports—the Old-age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund. This reallocation would assure that both funds are in a position to meet benefit obligations through the end of 1981 while further congressional action on the financing of the programs proceeds.

Three-month retroactivity of applications.—The committee bill would reduce the maximum retroactivity period of social security benefit applications. Under present law, an application may, in effect, be backdated as much as 12 months prior to the actual month of application. The committee bill would limit this retroactivity to no more than 3 months prior to application.

Limitation on circumstances under which prisoners may receive benefits.—Under the committee bill, social security benefits based on disability would not be payable to convicted felons except as specifically provided for by a court of law during their participation in an approved program of rehabilitation which is expected to result in their return to productive employment. In addition, the committee bill provides that an individual may not be considered a full-time student for purposes of student benefits while he is incarcerated. Moreover, any disabling condition arising in the commission of a crime would not be considered in determining whether an individual was under a disability for benefit purposes and any other disabling condition arising while an individual is imprisoned could not qualify him for disability benefits so long as he remains in prison.

Technical amendments.—The committee amendment includes a number of amendments of a purely technical nature to the Social Security Act. These amendments correct minor clerical and drafting errors in various amendments enacted in recent years.

II. General Discussion of the Bill

Monthly Exception To Apply in the Year Entitlement Ends for Certain Beneficiaries

(Section 1 of the bill)

The principal purpose of the provision of the Social Security Amendments of 1977 to eliminate the monthly measure of the earnings test was to prohibit a social security beneficiary who has substantial earnings after becoming entitled to benefits, i.e. in excess of the annual exempt amount, from using the monthly exception in order to

maximize the amount of the social security benefits he can receive during the year. Although the provision was designed primarily with retirees in mind, it has produced unforeseen results with respect to beneficiaries who are entitled to child's (including student's) benefits, or mother's benefits. These beneficiaries often have substantial earnings in the year in which they enter or reenter the work force. Under present law, they are subject to a strictly annual test in that year. If their earnings are above the exempt amount allowed under the annual test, the benefits they have received in the months prior to going to work may constitute overpayments and have to be repaid, either in part or in full. It has been pointed out that in many cases these beneficiaries cannot anticipate at the beginning of the year whether they will have earnings later in the year, or the amount of such earnings. Requiring repayment in this circumstance thus can cause financial hardship, and can also discourage the individual from going to work.

The committee bill would provide, in the case of an individual receiving wife's or widow's insurance benefits by reason of having a child in her care or in the case of an individual receiving child's or mother's (including father's) insurance benefits, that a monthly measure of excess earnings under the earnings test will be applied in the year in which the individual's entitlement to such benefits ends. As a result, in that year the individual could receive full benefits for any month in which he neither works for wages in excess of the monthly measure (one-twelfth of the annual exempt amount) nor renders substantial services in self-employment, regardless of the amount of annual earnings. It would not apply in cases where the beneficiary's entitlement ended by reason of death or entitlement to another type of social security benefit.

This provision would not prevent a person from using the monthly exception later in the first year he becomes entitled to a social security benefit as a retired worker. The change would be retroactive to January 1978 so that beneficiaries in these categories who lost benefits as a result of the 1977 amendments would have the benefits restored.

Separate Medicare Application

(Section 2 of the bill)

Under present law, an individual must file for social security cash benefits in order to be entitled to hospital insurance benefits under medicare. This is the case even though the individual will not be eligible for cash benefits because his earnings are too high. As a result, his "grace year" may be inadvertently triggered by an isolated month of no earnings or low earnings. When he actually retires in some later year, he is not eligible for the monthly test and may therefore be ineligible for cash benefits until the following year.

The committee bill would provide for separate applications for OASI benefits and for hospital insurance benefits in order to reserve the "grace year," the one year in which the beneficiary can use the monthly exception, for the year the person actually retires. The bill would provide that people who have already withdrawn their applications for cash and medicare benefits and repaid the cash and medicare benefits received in order to reserve their "grace year" for another

year would be deemed to have filed an application for medicare benefits as of the date the original application for cash and medicare benefits was filed. The provision of the bill would not impair the authority of the Secretary of HHS with respect to the retroactive payment of medicare benefits in the case of people whose previously withdrawn applications for medicare benefits are reinstated.

Similarly, under this provision, individuals who had been disadvantaged by the 1977 amendments would be able after enactment to withdraw their cash benefits applications without retroactive loss of medicare eligibility.

EXCLUSION OF CERTAIN SELF-EMPLOYMENT INCOME

(Section 3 of the bill)

The conversion to an annual test for all years except the year of retirement has brought into focus the issue of how certain kinds of earnings from self-employment should be treated for retirement test purposes.

Among those who claim that the conversion has affected them adversely are self-employed insurance agents, lawyers, accountants, real estate agents, and farmers. Under a combined annual-monthly earnings test in effect prior to 1978, a self-employed beneficiary could receive a benefit for any month in which he did not render substantial services in self-employment, even if his annual earnings were substantial. The primary test used to determine whether an individual had engaged in substantial services was whether he worked over 45 hours a month in self-employment. As a result, while the monthly earnings test was in effect, certain self-employed beneficiaries receiving income based on services rendered before retirement could receive 12 months of social security benefits so long as they did not breach the substantial services test.

Self-employed special and general insurance agents who sell insurance policies on which they receive renewal commissions—commissions that may have been planned for use as retirement income—have claimed to be particularly adversely affected. Under applicable tax law, income from the commissions is counted as income for social security and Federal income tax purposes in the year in which the income is received. As long as the monthly test was in effect, the agents could receive 12 months of social security benefits, since the test for self-employed beneficiaries under the substantial services test was 45 hours of work or less per month. With the monthly earnings test repealed, many of these agents lose some or all of their social security benefits when their commission income from sales in previous years is substantial.

Another group of self-employed beneficiaries similarly affected by the 1977 amendment is farmers. Prior law permitted farmers to sell a crop in a year after the year of retirement without having that income result in a loss of social security benefits for any month so long as the farmer did not perform substantial services in self-employment in any month of the year in which the crop was sold. Now that the substantial services test is limited to the year of retirement, income from the sale of a crop raised in the year of retirement or a year prior to retirement can affect a retired farmer's benefits under the annual earnings limitation,

whether or not he performs substantial services in the year of the sale.

Yet another group affected by the repeal of the monthly test are certain retired partners such as lawyers and accountants, and other persons who own or inherit businesses, and receive income from them after entitlement begins, but they too perform no substantial services. Under the monthly earnings test prior to 1978, individuals receiving such payments could also receive full social security benefits for any month in which they did not perform substantial services in self-employment. With elimination of the monthly test the payments from the business result in many cases in reductions or complete withholding of benefits.

The committee bill provides that self-employment income will not be counted for retirement test purposes unless it is based on services performed by the beneficiary after entitlement to social security benefits begins. All self-employment income of this type would be counted in the first year of entitlement, but benefits could be paid in that year inasmuch as the monthly measure would continue to be available in the first year of entitlement year as under present law. This provision would apply not only to old-age beneficiaries but to other categories such as widows. The provision would be made retroactive to January 1, 1978 and benefits would be recomputed for persons who lost benefits as a result of self-employment income of the type which is subject to exclusion under this provision.

Retrospective Effect of Elimination of Monthly Exception

(Section 4 of the bill)

The elimination of the monthly test under the 1977 Amendments was effective on a retrospective basis. In other words, it applied to beneficiaries who had received benefits prior to 1978. It did not affect their pre-1978 benefits, but it affected their benefits from 1978 on. As a result, any individual who filed an application for cash benefits and who had one or more months of earnings below the monthly exempt amount before January 1978 is considered to have already used the one "grace year" during which he is entitled to use the monthly test. This has had the effect of reducing or eliminating benefits to individuals who drew benefits prior to 1978, but had not yet actually retired. For example, a beneficiary who used his "grace year" before 1978 may substantially retire in the middle of some later year, but receive no benefits or reduced benefits for the rest of that year because of his earnings in the first 6 months. Retrospective application of the provision caught many beneficiaries unawares and without adequate opportunity to make personal retirement decisions necessary to meet the effects of the change to an annual earnings test.

The committee bill provides for the prospective application of the elimination of the monthly earnings test, that is, all beneficiaries would have the use of the monthly earnings test in at least one year after 1977. As a result, people who lost social security benefits under the retrospective implementation would have their benefits restored.

Reallocation of OASDI Taxes

(Section 5 of the bill)

The optimum level of reserves in the social security trust funds has generally been considered to be an amount equal to approximately one year's benefit payments. Because of high inflation and other factors, the funds in recent years have fallen far below these optimum levels. Although the 1977 amendments sought to restore somewhat the financial condition of the funds, adverse economic conditions have caused the reserve levels to continue to decline. The old-age and survivors insurance fund in particular has fallen to a level at which cash flow problems are projected to occur sometime in 1981.

The committee bill provides for a reallocation in 1980 and 1981 of the social security cash benefit tax receipts between the two trust funds supported by that tax—the disability fund and the old-age and survivors fund.

The financing of the social security program will require detailed review next year. However, under current estimates, the reallocation provided for in the bill would assure continuing cash flow capability for the cash benefit trust funds through the end of 1981 by reallocating the existing cash benefit tax rate as shown below. (This reallocation would have no impact on the Medicare trust funds.)

CASH BENEFITS SOCIAL SECURITY TAX RATES—EMPLOYER AND EMPLOYEE, EACH

[In percent]

Year	Present law			Committee amendment		
	OASI	DI	Total tax	OASI	DI	Total tax
1980	4.33	0.75	5.08	4.52	0.56	5.08
1981	4.525	.825	5.35	4.70	.65	5.35

CASH BENEFITS SOCIAL SECURITY TAX RATES—SELF-EMPLOYED PERSONS

[In percent]

Year	Present law			Committee amendment		
	OASI	DI	Total tax	OASI	DI	Total tax
1980	6.01	1.04	7.05	6.2725	0.7775	7.05
1981	6.7625	1.2375	8.00	7.025	.975	8.00

END-OF-YEAR CASH BENEFIT FUND BALANCES

[As a percent of following year outgo]

Year	Present law			Committee amendment		
	OASI	DI	Combined funds	OASI	DI	Combined funds
1980	14	43	17	17	19	17
1981	4	58	10	10	11	10

Note: Estimated by Social Security Administration actuaries; based on Administration July mid-session budget review assumptions.

Limit on Retroactive Benefits

(Section 6 of the bill)

Individuals who apply for benefits under the social security program are now effectively allowed to backdate their applications by as much as 1 year to claim benefits for months prior to the actual date of application. In the last Congress, the Administration submitted a recommendation with its fiscal 1979 budget to change this provision so as to limit retroactivity of applications to a period of 3 months. The old-age, survivors, and disability insurance program is intended to provide a source of monthly income for persons whose support in the form of wages of an insured worker is reduced because of that worker's death, disability, or retirement. Ordinarily, individuals who may be eligible for benefits apply for benefits promptly upon becoming eligible or even some months in advance of eligibility. In some instances, however, an individual may not file an application until after eligibility has already existed for some time. A period of retroactivity prior to the month of application is provided to protect against loss of benefits based on delayed filing which may have resulted from circumstances beyond the individual's control.

The committee bill limits the period of potential retroactivity to 3 months. The committee believes that a retroactivity period of 3 months prior to the month of application should provide ample opportunity for individuals to meet the program's filing requirements. The 3-month period would run from the date the application is filed and not from the date on which a decision is made on the claim.

Benefits for Certain Prisoners

(Section 7 of bill)

Individuals who are inmates of penal institutions or other incarcerated persons, such as the criminally insane who are confined to mental institutions, may become entitled to social security benefits if they can meet the several conditions required for benefits. The fact

that they have been convicted of crimes and are incarcerated or are otherwise institutionalized does not interfere with their rights to benefits. This is in contrast to the old public assistance programs of the act (titles I, X, XIV) and the new supplemental security income program (title XVI), all of which explicitly deny payments to an inmate of a "public institution." That exclusion applies to prison inmates and also to other individuals who are residing voluntarily or involuntarily in institutions maintained by public funds.

Two related social security provisions of current law and regulation, however, do authorize the withholding of benefits to persons convicted of certain crimes. One originated as an amendment to the Social Security Act of 1956, which allows a judge, as part of a sentence, to deny payment of social security benefits of any type to an individual convicted of subversive crimes against the U.S. Government (espionage, sabotage, treason, sedition, etc.).

The second provision, provided for by regulation, precludes paying benefits to people convicted of killing a relative, and then claiming benefits based on the earnings record of the person they killed.

The data on the number of incarcerated persons receiving social security benefits is limited. Data from the 1970 census showed that approximately 4,000 prisoners in Federal, State and local penal institutions were receiving some form of social security benefits. A recent rough analysis of Federal prison inmates performed by GAO showed that 224 such inmates out of 17,000 who had known social security numbers were receiving benefits (approximately 1.5 percent). Another 5,000 inmates appeared not to have social security numbers, or their numbers were not known. Based on these data, the actuaries estimate that approximately 6,000 prisoners are now receiving social security benefits.

The committee believes that the basic purposes of the social security program are not served by the unrestricted payment of benefits to individuals who are in prison or whose eligibility arises from the commission of a crime. The disability program exists to provide a continuing source of monthly income to those whose earnings are cut off because they have suffered a severe disability. The need for this continuing source of income is clearly absent in the case of an individual who is being maintained at public expense in prison. The basis for his lack of other income in such circumstances must be considered to be marginally related to his impairment at best.

The committee bill therefore would require the suspension of benefits to any individual who would otherwise be receiving them on the basis of disability while he is imprisoned by reason of a felony conviction. This suspension would apply except to the extent that a court of law specifically provides to the contrary as a part of its approval of a plan of vocational rehabilitation services for that individual, and only for so long as the individual continues to participate satisfactorily in an approved vocational rehabilitation program which is expected to result in his return to substantial gainful employment. The committee amendment would also provide that an individual may not be considered to be a full-time student for purposes of social security student benefits while he is incarcerated. In addition, the amendment provides that disabilities to the extent that they arise from or are aggravated during the commission of a crime may not

be considered in determining whether or not an individual qualifies for social security benefits. Impairments not arising from the commission of a crime but occurring while an individual is in prison could not be considered for purposes of disability eligibility so long as the individual remains in prison.

Technical Corrections

(Section 8 of the bill)

The committee bill includes a number of amendments of a purely technical nature to the Social Security Act. These amendments correct minor clerical and drafting errors in various amendments enacted in recent years.

III. Regulatory Impact of the Bill

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate the following evaluation is made of the regulatory impact which would be incurred in carrying out the bill.

Those provisions of the bill which relate to the social security retirement test (sections 1–4) represent an easing of legislation enacted in 1977. No significant regulatory, paperwork, or privacy impact is expected. Individuals affected by these provisions may be required to provide some additional information but this would not be substantially different in character or complexity from other information requirements typically involved in establishing benefit eligibility. Inasmuch as these provisions will permit benefit payments which were precluded by the 1977 amendments, the economic impact on affected individuals will be favorable to them.

Section 5 of the bill is an accounting transaction between two social security trust funds which has no impact of a regulatory nature. Section 6 simply reduces an existing law limit on the retroactivity of benefits from 12 months to 3 months prior to the month of application. It should have no impact of a regulatory, paperwork, or privacy nature and should affect only those relatively few applicants who do not file for benefits until some months after they have become eligible for them. Section 7 places limitations on the payment of benefits to prisoners and to persons who become disabled in the commission of criminal actions. Because of the relatively small number of individuals affected, the Committee believes that this provision has no significant regulatory impact. It is estimated that about 6,000 persons are now receiving benefits while in prison. For those affected, there will be some impact on economic status and on privacy (in that the Social Security Administration will be required to determine that they are in prison and that their disabilities arose in the commission of crimes). The committee does not consider these impacts to be inappropriate.

IV. Vote of the Committee in Reporting the Bill

In compliance with paragraph 7(c) of rule XXVI of the Standing Rules of the Senate, the following statement is made relative to the vote by the committee to report the bill.

The bill was ordered reported by a voice vote.

TABLE 1.—ESTIMATED COST TO OASI TRUST FUND RESULTING FROM PROVISIONS OF H.R. 5295 AFFECTING ANNUAL EARNINGS TEST

[By fiscal years, in millions of dollars] [1]

	1981	1982	1983	1984	1985
Provides monthly earnings test in year they leave the rolls for mothers of young children and for students [2]	0	47	29	31	34
Separate medicare application	−4	3	7	10	13
Exclusion of deferred income	36	14	15	16	17
Allowance of at least 1 full earnings test year	58	2	0	0	0
Total cost	90	66	51	57	64

[1] Based on an Oct. 1, 1980 effective date.
[2] Includes administrative savings.

The first section of the bill applicable to the earnings test allows a monthly earnings test to be applied to mothers, children and students for the year in which they leave the benefit rolls. For these groups, under current law, the only year of exemption from the annual earnings test is the year during which benefits were first received.

This provision is retroactive to January 1, 1978, but it is not expected that this provision will affect costs prior to 1982 since it applies to the year benefits are terminated, and it is assumed that overpayments for 1978 and later would not have been recovered until 1982. This bill would eliminate the need to administratively determine who had received these overpayments, and of collecting them, and thus the increase in benefit costs are offset by the savings in these administrative costs. Thus, the first year costs of $47 million will not occur until fiscal year 1982.

The next section of the bill provides for a separate application for medicare at age 65. This provision protects those who wish to continue working from using their one year exemption from the annual earnings test until they are ready to cease work and retire. There is a savings from this provision in the first year since many of those "retiring" only for medicare purposes do collect one or two months of retirement benefits although still working. This provision, in effect, allows these workers to waive these benefits until they retire. These workers would then collect higher benefits in the future. There is a retroactive feature in this provision.

It is probable that there will be some additional costs to the HI and SMI trust funds as a result of an incentive for some workers to sign up for medicare benefits under this provision who had not done so under current law. These costs are expected to be minimal.

The third section of the bill affecting those with earnings excludes from income, for earnings test purposes, all self-employment income that is the result of services performed in past years. Most of those affected by this provision are retired insurance salesmen and farmers.

Finder's Aid

P. L. 96-499 (94 STAT. 2599) Approved December 5, 1980
"Omnibus Reconciliation Act of 1980"

SUBJECT	SS Act Section	P. L. Section	94 Stat.	H. Rep. 96-1167	H. Con. Rep. 96-1479
Monthly Insurance Benefits—Application—Retroactive Effect	202(j)(1)	1011(a)	2655	—	62,159
Definition of Wages—Taxes Paid by Employer	209(f)	1141(a)(2)	2693	530	102
Home Health Services	226(c)(1)	930(q)(1)	2633	367,531	38,129
Home Health Services	226(c)(1)(B)	930(q)(2)	2633	531	38, 129
Maternal and Child Cases—Approval of State Plan (Technical Amendment)	505(a)(14)	914(c)(1)(A)	2622	531	26
Maternal and Child Cases—Approval of State Plan (Technical Amendment)	505(a)(15)	914(c)(1)(B)	2622	532	26
Maternal and Child Cases—Approval of State Plan—Audits	505(a)(16) (new)	914(c)(1)(C)	2622	532	26-27
Federal Employees Compensation Account	909 (new)	1023(a)	2657	—	64
Clinical Laboratories—Qualifications—Health Care Personnel	1123(a)	911	2619	65,105, 124-125, 533	23, 144
HIB--Disclosure of Ownerships and Financial Interest	1124(a)(3) (A)(ii)	912(a)	2619	59-60, 99, 125-126, 534	23, 142
Individuals Convicted of Medicare- or Medicaid-Related Crimes	1128 (new)	913(a)	2619	59, 98-99, 126-127, 534	23-24, 142
Coordinated Audits	1129 (new)	914(a)	2621	63-64, 101-103, 127-128, 535	25-26, 143
Nonprofit Hospital—Philanthropy	1134 (new)	901(a)	2611	131-132, 407, 539-540	14-15, 139-140
PSRO—Expansion of Membership	1152(b)(1)(A)	921(1)	2627	47, 93, 400-401, 540	32, 137
PSRO—Expansion of Membership	1152(b)(1)(A)	921(2)	2628	540	32, 137
Trial Period for PSRO	1154(b)	924(a)(1)(A)	2628	49-51, 94, 402-404, 541	33, 138
Trial Period for PSRO—"Qualified Organization"	1154(b)	924(a)(1)(B)	2628	94, 402-404, 541	33, 138
Trial Period for PSRO—Required Activities	1154(c)	924(a)(2)	2629	94, 541	33, 138

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P. L. 96-499 (Cont.)

SUBJECT	SS Act Section	P. L. Section	94 Stat.	H. Rep. 96-1167	H. Con. Rep. 96-1479
Trial Period for PSRO—Cost Effectiveness	1154(f) (new)	924(a)(3)	2629	49-51, 94-95, 133-134, 402-404, 541-542	33-34, 138
Duties and Functions of PSRO	1155(a)	924(b)(1)	2629	96, 134, 542-543	34
PSRO—Routine Hospital Admission Services and Preoperative Hospital Stays	1155(a)(2)	926	2630	53, 96, 134, 406, 543	35, 139
PSRO—Required Activities	1155(a)(7)(A)	924(b)(2)	2629	135, 543	34
PSRO—Required Activities	1155(a)(7)(B)	924(b)(3)	2629	135, 543	34
Consultation by PSRO with Health Care Practitioners	1155(a)(8) (new)	927(a)	2630	52-53, 95, 135, 405-406, 543	35, 138-139
PSRO—Efficiency in Delegated Review	1155(e)	925	2630	48, 94, 135, 402, 544	34, 138
PSRO—Review Responsibility in Shared Health Facilities	1155(g) (Repealed)	924(c)	2629	49-50, 95, 136, 544	34
PSRO—Review	1155(h) (new)	924(d)	2629	51, 95, 136, 402, 544	34
PSRO—Detoxification Facility Services	1155(i) (new)	931(g)	2634	—	39
HIB—Review—Condition of Payment—Detoxification Facility	1158(a)	931(h)	2634	—	39,40
HIB—Review—Condition of Payment	1158(d)	902(a)(3)	2613	—	16
Hospital Inpatient Care More Economical in Detoxification Facility	1158(e) (new)	931(h)(2)	2634	—	39-40
Statewide PSRC—Inclusion of Registered Nurse and Doctor of Dental Surgery/ Medicine	1162(e)(1)	922(a)	2628	48, 94, 136, 401, 545	32, 137
Statewide PSRC— States not having Councils	1162(e)(1)	927(b)	2630	136, 405-406, 545	35, 138-139
Statewide PSRC—States not having Councils	1162(e)(2)	927(b)	2630	405-406, 545	35, 138-139
National PSRC—Non-physician Membership	1163(a)(1)	923(a)	2628	48, 94, 136-137, 401, 545	33, 137-138
National PSRC—Expiration of Terms	1163(a)(2)	923(b)	2628	94, 137, 545	33
National PSRC—Physician as Chairman	1163(a)(3)	923(c)	2628	94, 137, 545	33

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SUBJECT	SS Act Section	P. L. Section	94 Stat.	H. Rep. 96-1167	H. Con. Rep. 96-1479
National PSRC—Physician Members	1163(b)	923(d)	2628	137, 545	33
Physicians—American Samoa; Northern Marianna Islands; Trust Territory of the Pacific Islands	1173	923(e)	2628	94, 136, 545-546	33
HIB—Home Health Services	1811	930(a)	2631	546	36, 129
HIB (Technical Amendment)	1812(a)(2)	931(a)	2633	546	38
HIB—Home Health Services	1812(a)(3)	930(b)	2631	367-368, 546	36, 129
HIB (Technical Amendment)	1812(a)(3)	931(a)	2633	546	38
HIB—Alcohol Detoxification	1812(a)(4) (new)	931(a)	2633	—	38
HIB—Home Health Services	1812(d) (Repealed)	930(c)	2631	367-368, 546	36, 129
HIB (Technical Amendment)	1812(e)	930(d)(1)	2631	547	36
HIB	1812(e)	930(d)(2)	2631	547	36
HIB—Home Health Services	1814(a)(2)(D)	930(f)(1)	2631	548	36
HIB—Home Health Services—Occupational Therapy	1814(a)(2)(D)	930(f)(2)	2631	549	36
HIB—Home Health Services	1814(a)(2)(D)	930(f)(3)	2631	548	36
HIB—Request and Certification (Technical Amendment)	1814(a)(2)(D)	931(b)	2633	—	38
HIB—Request and Certification (Technical Amendment)	1814(a)(2)(E)	931(b)	2633	—	38
HIB—Dentists' Services—Severity of Procedure	1814(a)(2)(E)	936(b)	2640	372, 549	45, 129-130
HIB—Alcohol Detoxification Facility Services	1814(a)(2)(F) (new)	931(b)	2633	—	39-40
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Public Law 96-499
96th Congress

An Act

To provide for reconciliation pursuant to section 3 of the First Concurrent Resolution on the Budget for the fiscal year 1981.

Dec. 5, 1980
[H.R. 7765]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Omnibus Reconciliation Act of 1980.

TITLE I—SHORT TITLE AND DECLARATION OF PURPOSE

SHORT TITLE

SECTION 101. This Act may be cited as the "Omnibus Reconciliation Act of 1980".

PURPOSE

SEC. 102. It is the purpose of this Act to implement the recommendations which were made by specified committees of the House of Representatives and the Senate pursuant to directions contained in section 3 of the First Concurrent Resolution on the Budget for the fiscal year 1981 (H. Con. Res. 307, 96th Congress), and pursuant to the reconciliation requirements which were imposed by such concurrent resolution as provided in section 310 of the Congressional Budget Act of 1974. 31 USC 1331.

TITLE II—SCHOOL LUNCH AND CHILD NUTRITION PROGRAMS

Subtitle A—Savings Under the School Lunch and Child Nutrition Programs

REDUCTION IN GENERAL REIMBURSEMENT

SEC. 201. (a) Notwithstanding section 4 of the National School Lunch Act, for the fiscal year ending September 30, 1981, the national average payment per lunch under such Act for such fiscal year, after being adjusted under section 11(a) of such Act, shall be reduced by 2½ cents for any school food authority under which less than 60 percent of the lunches served in the school lunch program were served free or at reduced price during the second preceding school year. The amount of State administrative expense funds to be made available to the States by the Secretary of Agriculture under section 7 of the Child Nutrition Act of 1966 for the fiscal year ending September 30, 1983, and the amount of State revenues appropriated or used for meeting the requirements under section 7 of the National School Lunch Act for the school year ending June 30, 1982, shall not be reduced because of a reduction in the amount of Federal funds expended as a result of

42 USC 1753 note.
42 USC 1759a.
42 USC 1776.
42 USC 175b.

(15 U.S.C. 1409) not more than $53,800,000 is authorized to be appropriated in fiscal year 1981.".

SEC. 512. (a) For provisions of law which reduce spending for fiscal year 1981 under the railroad rehabilitation and improvement financing program established under title V of the Railroad Revitalization and Regulatory Reform Act of 1976 in satisfaction of the reconciliation requirements imposed by sections 3(a)(3) and 3(a)(13) of H. Con. Res. 307 (96th Congress), see the Staggers Rail Act of 1980 (Public Law 96-448). 45 USC 821. *Ante*, p. 1895.

(b) For provisions of law which further reduce spending for fiscal year 1981 in satisfaction of the reconciliation requirements imposed by sections 3(a)(3) and 3(a)(13) of H. Con. Res. 307 (96th Congress), see the Passenger Railroad Rebuilding Act of 1980 (Public Law 96-254). *Ante*, p. 399.

TITLE VI—AIRPORT AND AIRWAY IMPROVEMENT ACT

SEC. 601. Notwithstanding any other provision of law, the total amount of grants which the Secretary is authorized to make from the Airport and Airway Trust Fund for airport development and airport planning and for grants under section 104(e) of the Airport Safety and Noise Abatement Act of 1979, as amended, for the fiscal year ending September 30, 1981, shall not exceed $725,000,000.

TITLE VII—VETERANS' PROGRAMS

SEC. 701. For provisions of law which reduce spending for fiscal year 1981 in veterans' programs in satisfaction of the reconciliation requirements imposed by sections 3(a)(7) and 3(a)(20) of H. Con. Res. 307 (96th Congress), see section 401 of the Veterans' Administration Health-Care Amendments of 1980 (Public Law 96-330), section 504 of the Veterans' Disability Compensation and Housing Benefits Amendments of 1980 (Public Law 96-385), and sections 201, 202, 211, 212, and 802(b), and title VI, of the Veterans' Rehabilitation and Education Amendments of 1980 (Public Law 96-466). *Ante*, p. 1051. *Ante*, p. 1534. *Ante*, pp. 2187-2190, 2217, 2208.

TITLE VIII—SMALL BUSINESS PROGRAMS

SEC. 801. For provisions of law which reduce spending for fiscal 1981 in small business programs in satisfaction of the reconciliation requirements imposed by sections 3(a)(6) and 3(a)(19) of H. Con. Res. 307 (96th Congress), see Public Law 96-302 (the Small Business Development Act of 1980). *Ante*, p. 833.

TITLE IX—MEDICARE AND MEDICAID RELATED PROVISIONS

Medicare and Medicaid Amendments of 1980.

SHORT TITLE; TABLE OF CONTENTS OF TITLE

SEC. 900. This title may be cited as the "Medicare and Medicaid Amendments of 1980". 42 USC 1305 note.

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PART A—PROVISIONS RELATING TO MEDICARE AND MEDICAID

Subpart I—Provider Reimbursement Changes

NONPROFIT HOSPITAL PHILANTHROPY

SEC. 901. (a) Part A of title XI of the Social Security Act is amended by adding at the end thereof the following new section:

"NONPROFIT HOSPITAL PHILANTHROPY

"SEC. 1134. For purposes of determining, under titles V, XVIII, and XIX of this Act, the reasonable costs of services provided by nonprofit hospitals, the following items shall not be deducted from the operating costs of such hospitals: 42 USC 1320b-4. 42 USC 701, 1395, 1396.

"(1) A grant, gift, or endowment, or income therefrom, which is to or for such a hospital and which has not been designated by the donor for paying any specific operating costs.

"(2) A grant or similar payment which is to such a hospital, which was made by a governmental entity, and which is not available under the terms of the grant or payment for use as operating funds.

"(3) Those types of donor designated grants and gifts (including grants and similar payments which are made by a governmental entity), and income therefrom, which the Secretary determines, in the best interests of needed health care, should be encouraged.

"(4) The proceeds from the scale or mortgage of any real estate or other capital asset of such a hospital, which real estate or asset the hospital acquired through gift or grant, if such proceeds are not available for use as operating funds under the terms of the gift or grant.

Paragraph (4) shall not apply to the recovery of the appropriate [illegible]e of depreciation when gains or losses are realized from the dis[illegible]f depreciable assets.".

(b) The amendment made by subsection (a) shall apply to gi[illegible] gifts, and endowments, and income therefrom, made or establis[illegible] after the date of the enactment of this Act. 42 USC 1320b-4 note.

REIMBURSEMENT FOR INAPPROPRIATE INPATIENT HOSPITAL SERVICES

42 USC 1395x

SEC. 902. (a)(1) Section 1861(v)(1) of the Social Security Act is amended by adding at the end thereof the following new subparagraph:

"(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute post-hospital extended care services if provided by a skilled nursing facility and a Professional Standards Review Organization (or, in the absence of such a qualified organization, an organization or agency with review responsibility as

42 USC 1301

is otherwise provided for under part A of title XI) determines that inpatient hospital services for the individual are not medically necessary but post-hospital extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

"(I) such post-hospital extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

"(II) inpatient hospital services for the individual are not medically necessary, and

"(III) the individual is entitled to have payment made for post-hospital extended care services under this title,

except that if the Secretary determines that the hospital had (during the immediately preceding calendar year) an average daily occupancy rate of 80 percent or more, such payment shall be made (during such period) on the basis of the reasonable cost of inpatient hospital services.

"(ii)(I) Except as provided in subclause (II), the payment rate referred to in clause (i) is a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled

42 USC 1396.

nursing facilities under the State plan approved under title XIX for the State in which such hospital is located, or, if the State in which the hospital is located does not have a State plan approved under title XIX, the estimated adjusted State-wide average allowable costs per patient-day for extended care services under this title in that State.

"(II) If a hospital has a unit which is a skilled nursing facility, the payment rate referred to in clause (i) for the hospital is a rate equal to the lesser of the rate described in subclause (I) or the allowable costs in effect under this title for extended care services provided to patients of such unit.

"(iii) Any day on which an individual receives inpatient services for which payment is made under this subparagraph shall, for purposes of this Act (other than this subparagraph), be deemed to be a day on which the individual received inpatient hospital services.

Occupancy rate.

"(iv) For the purpose of determining the occupancy rate with respect to hospitals under clause (i)—

"(I) public hospitals under common ownership may elect (with the approval of the Secretary) to be treated as a single hospital, and

"(II) beginning two years after the date this subparagraph is first applied with respect to a hospital, the Secretary, to the extent feasible, shall not treat as an inpatient an individual with respect to whom payment is made to the hospital only because of this subparagraph or section 1902(h).".

42 USC 1396a.

(2) For amendment to section 1158(a) of the Social Security Act relating to these provisions, see section 931(h) of this title. *Post*, p. 2633.

(3) Section 1158(d) of such Act is amended by adding at the end the following new sentence: "In the case of disapproval of inpatient hospital services where payment for inpatient services is continued under section 1861(v)(1)(G) or section 1902(h), the previous sentence shall not apply with respect to such disapproval.". 42 USC 1320c-7. *Ante*, p. 2612, *infra*.

(b)(1) Section 1902(a)(13)(D) of such Act is amended— 42 USC 1396a.

(A) by inserting "(i)" after "(D)",

(B) by striking out the semicolon and inserting in lieu thereof a comma, and

(C) by inserting at the end thereof the following new clause: "(ii) for payment of the reasonable cost of inappropriate inpatient services (described in subsection (h)(1)) for which payment is provided only because of subsection (h) at the rate of payment for such services provided for under such subsection, and". *Infra*.

(2) Section 1902 of such Act is further amended by adding at the end the following new subsection: 42 USC 1396a.

"(h)(1) In any case in which a hospital provides inpatient services to an individual that would constitute skilled nursing facility services if provided by a skilled nursing facility or that would constitute intermediate care facility services if provided by an intermediate care facility and a Professional Standards Review Organization (or, in the absence of such a qualified organization, an organization or agency with review responsibility as is otherwise provided for under part A of title XI) determines that inpatient hospital services for the individual are not medically necessary but skilled nursing facility services or intermediate care facility services, respectively, for the individual are medically necessary and such type of facility services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for inpatient hospital services shall continue to be made under the State plan approved under this title at the payment rate described in paragraph (2) for such type of services during the period in which— 42 USC 1301.

"(A) such skilled nursing facility services or intermediate care facility services (as the case may be) for the individual are medically necessary and not otherwise available to the individual (as so determined),

"(B) inpatient hospital services for the individual are not medically necessary, and

"(C) the individual is entitled to receive medical assistance with respect to such facility services under the State plan, except that if the Secretary determines that the hospital had (during the immediately preceding calendar year) an average daily occupancy rate of 80 percent or more, such payment shall be made (during such period) on the same basis as otherwise used under the State's plan for payments for providing inpatient hospital services.

"(2)(A) Except as provided in subparagraph (B), the payment rate referred to in paragraph (1), in the case of skilled nursing facility services or intermediate care facility services, is the estimated adjusted State-wide average rate per patient-day paid for such respective type of services provided under the State plan.

"(B) If a hospital has a unit which is a skilled nursing facility or intermediate care facility, the payment rate referred to in paragraph (1), in the case of inpatient services which constitute skilled nursing facility services or intermediate care facility services, is a rate equal to the lesser of the rate described in subparagraph (A) or the

allowable costs in effect under the State plan for such type of inpatient services provided to patients of such unit.

"(3) Any day on which an individual receives inpatient services for which payment is made under this subsection shall, for purposes of this Act (other than this subsection), be deemed to be a day on which the individual received inpatient hospital services.

"(4) For the purpose of determining the occupancy rate with respect to hospitals under paragraph (2)—

"(A) public hospitals under common ownership may elect (with the approval of the Secretary) to be treated as a single hospital, and

"(B) beginning two years after the date this subsection is first applied with respect to a hospital, the Secretary, to the extent feasible, shall not treat as an inpatient an individual with respect to whom payment is made to the hospital only because of this subsection or section 1861(v)(1)(G).".

Effective date. 42 USC 1320c-7 note.

(c) The amendments made by this section shall become effective on the date of which final regulations, promulgated by the Secretary to implement such amendments, are first issued; and those regulations shall be issued not later than the first day of the sixth month following the month in which this Act is enacted.

CONTINUED USE OF DEMONSTRATION PROJECT REIMBURSEMENT SYSTEMS

42 USC 1395f.

SEC. 903. (a) Section 1814(b) of the Social Security Act is amended—

(1) by inserting "except as provided in paragraph (3)," in paragraph (1) before "the lesser",

(2) by striking out "or" at the end of paragraph (1),

(3) by striking out the period at the end of paragraph (2) and inserting in lieu thereof "; or", and

(4) by adding at the end thereof the following new paragraph:

"(3) if some or all of the hospitals in a State have been reimbursed for services (for which payment may be made under this part) pursuant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972, if the rate of increase in such hospitals in their costs per hospital inpatient admission of individuals entitled to benefits under this part over the duration of such project was equal to or less than such rate of increase for admissions of such individuals with respect to all hospitals in the United States during such period, and if either the State has legislative authority to operate such system and the State elects to have reimbursement to such hospitals made in accordance with this paragraph or the system is operated through a voluntary agreement of hospitals and such hospitals elect to have reimbursement to those hospitals made in accordance with this paragraph, then the Secretary may provide for continuation of reimbursement to such hospitals under such system until the Secretary determines that—

42 USC 1395b-1, 1395ll.
42 USC 1395b-1 and note, 1395ll.

"(A) a third-party payor reimburses such a hospital on a basis other than under such system, or

"(B) the rate of increase for the previous three-year period in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part is greater than such rate of increase for admissions of such individuals

with respect to all hospitals in the United States for such period.

In the case of any State which has had such a demonstration project reimbursement system in continuous operation since July 1, 1977, the Secretary shall provide under paragraph (3) for continuation of reimbursement to hospitals in the State under such system until the Secretary determines that either of the conditions described in subparagraph (A) or (B) of such paragraph has occurred.".

(b) Section 1902(a)(13)(D)(i) of such Act, as amended by section 902(b)(1) of this title, is amended by inserting after "title XVIII" the following: ", except that in the case of hospitals reimbursed for services under part A of title XVIII in accordance with section 1814(b)(3), the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section". 42 USC 1396a. 42 USC 1395. *Ante*, p. 2614.

(c) Notwithstanding any other provision of law, the Secretary of Health and Human Services (hereinafter in this title referred to as the "Secretary") may not provide for more than a total of six Statewide medicare hospital reimbursement demonstration projects under the authority of section 402 of the Social Security Amendments of 1967 or of section 222 of the Social Security Amendments of 1972, including any such projects provided for before the date of the enactment of this Act. 42 USC 1395b-1 note. 42 USC 1395b-1 and note, 1395*ll*.

HOSPITAL PROVIDERS OF LONG-TERM CARE SERVICES ("SWING-BEDS")

SEC. 904. (a)(1) Title XVIII of the Social Security Act is amended by adding after section 1882 the following new section:

"HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

"SEC. 1883. (a)(1) Any hospital (other than a hospital which has in effect a waiver under subparagraph (A) of the last sentence of section 1861(e)) which has an agreement under section 1866 may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services. 42 USC 1395 tt. *Post*, p. 2645, 42 USC 1395cc.

"(2)(A) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this section shall be based upon the reasonable cost of the services as determined under subparagraph (B).

"(B)(i) The reasonable cost of the services consists of the reasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services (determined under clause (iii)).

"(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this section is equal to the product of—

"(I) the number of patient-days during the year for which the services were furnished, and

"(II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the previous calendar year under the State plan (of the State in which the hospital is located) under title XIX to skilled nursing facilities located in the State and which meet the requirements specified in section 1902(a)(28), or, in the case of a hospital located in a State which does not have such a State plan, the average rate per patient-day 42 USC 1396. 42 USC 1396a.

paid for routine services during the previous calendar year under this title to skilled nursing facilities in such State.

"(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

"(b) The Secretary may not enter into an agreement under this section with any hospital unless—

"(1) except as provided under subsection (g), the hospital is located in a rural area and has less than 50 beds, and

"(2) the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 1521 of the Public Health Service Act) for the State in which the hospital is located.

42 USC 300m.

"(c) An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866 and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866, or during which there is in effect for the hospital a waiver under subparagraph (A) of the last sentence of section 1861(e). A hospital with respect to which an agreement under this section has been terminated shall not be eligible to enter into a new agreement until a two-year period has elapsed from the termination date.

42 USC 1395cc.

Post, p. 2645.

"(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

"(e) During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement due for routine services from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine title XVIII reimbursement for routine hospital services.

42 USC 1395, 1396.

"(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those

42 USC 1395x.

requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

"(g) The Secretary may enter into an agreement under this section on a demonstration basis with any hospital which does not meet the requirement of subsection (b)(1), if the hospital otherwise meets the requirements of this section.".

(b) Title XIX of such Act is amended by adding after section 1912 the following new section:

"HOSPITAL PROVIDERS OF SKILLED NURSING AND INTERMEDIATE CARE SERVICES

"SEC. 1913. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under a State plan approved under this title for skilled nursing facility services and intermediate care facility services furnished by a hospital which has in effect an agreement under section 1883. 42 USC 1396*l*.

"(b)(1) Payment to any such hospital, for any skilled nursing or intermediate care facility services furnished pursuant to subsection (a), shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under the State plan to skilled nursing and intermediate care facilities, respectively, located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

"(2) With respect to any period for which a hospital has an agreement under section 1883, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services due from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine reimbursement for routine hospital services under the State plan.". *Ante*, p. 2615. 42 USC 1395, 1396.

(c) Within three years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Congress a report evaluating the programs established by the amendments made by this section and shall include in such report an analysis of— Report to Congress. 42 USC 1395tt note.

(1) the extent and effect of the agreements under such programs on availability and effective and economical provision of long-term care services,

(2) whether such programs should be continued,

(3) the results of any demonstration projects conducted under such programs, and

(4) whether eligibility to participate in such programs should be extended to other hospitals, regardless of bed size or geographic location, where there is a shortage of long-term care beds.

(d) The amendments made by this section shall become effective on the date on which final regulations, promulgated by the Secretary to implement such amendments, are first issued; and those regulations shall be issued not later than the first day of the sixth month following the month in which this Act is enacted. 42 USC 1395tt note.

WITHHOLDING OF FEDERAL SHARE OF PAYMENTS TO MEDICAID PROVIDERS TO RECOVER MEDICARE OVERPAYMENTS

42 USC 1396a *Post*, p. 2650 *Infra*

SEC. 905. (a) Subparagraphs (D)(i) and (E) of section 1902(a)(13) of the Social Security Act are each amended by inserting "(except where the State agency is subject to an order under section 1914)" after "payment".

42 USC 1396b

(b) Section 1903(a)(1) of such Act is amended by striking out "subject to subsections (g) and (h)" and inserting in lieu thereof "subject to subsections (g), (h), and (j)".

(c)(1) Section 1903(j) of such Act is amended to read a follows:

"(j) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1914.".

Infra

(2) Section 1903(n) of such Act is amended by striking out "or is subject to a suspension of payment order issued under subsection (j)".

(d) Title XIX of such Act is amended by adding after section 1913 (added by section 904(b) of this title) the following new section:

"WITHHOLDING OF FEDERAL SHARE OF PAYMENTS FOR CERTAIN MEDICARE PROVIDERS

42 USC 1396m.

"SEC. 1914. (a) The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for medical assistance for care or services furnished in any quarter by—

"(1) an institution (A) which has or previously had in effect an agreement with the Secretary under section 1866; and (B)(i) from which the Secretary has been unable to recover overpayments made under title XVIII, or (ii) from which the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII; and

42 USC 1395cc.

42 USC 1395.

"(2) any person (A) who (i) has previously accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii), and (ii) during the annual period immediately preceding such quarter submitted no claims for payment under title XVIII, or submitted claims for payment under title XVIII which aggregated less than the amount of overpayments made to him, and (B)(i) from whom the Secretary has been unable to recover overpayments received in violation of the terms of such assignment, or (ii) from whom the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such person under title XVIII.

42 USC 1395u.

"(b) The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this title for any quarter by an amount equal to the lesser of the Federal matching share of payments to any institution or person specified in subsection (a), or the total overpayments to such institution or person under title XVIII, and may require the State to reduce its payment to such institution or person by such amount.

Notice.

"(c) The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to an institution or person, pursuant to subsection (b) until after he has provided adequate notice (which shall be not less than 60 days) to the State agency and the institution or person.

Implementation procedures.

"(d) The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall (1) determine

the amount of the Federal payment to which the institution or person would otherwise be entitled under this section which shall be treated as a setoff against overpayments under title XVIII, and (2) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under title XVIII and to which the institution or person would otherwise be entitled under this title. 42 USC 1395.

"(e) The Secretary shall restore to the trust funds established under sections 1817 and 1841, as appropriate, amounts recovered under this section as setoffs against overpayments under title XVIII. 42 USC 1395i, 1395t.

"(f) Notwithstanding any other provision of this title, an institution or person shall not be entitled to recover from any State any amount in payment for medical care and services under this title which is withheld by the State agency pursuant to an order by the Secretary under subsection (b).".

Subpart II—Other Administrative Provisions

QUALITY ASSURANCE PROGRAMS FOR CLINICAL LABORATORIES

SEC. 911. Section 1123(a) of the Social Security Act is amended by striking out "1977" and inserting in lieu thereof "1981". 42 USC 1320a-2.

REQUIREMENTS CONCERNING REPORTING OF FINANCIAL INTEREST

SEC. 912. (a) Section 1124(a)(3)(A)(ii) of the Social Security Act is amended to read as follows: 42 USC 1320a-3.

"(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds $25,000 or 5 per centum of the total property and assets of the entity; or".

(b) Section 1902(a)(35) of such Act is amended to read as follows: 42 USC 1396a.

"(35) provide that any disclosing entity (as defined in section 1124(a)(2)) receiving payments under such plan complies with the requirements of section 1124;". 42 USC 1320a-3.

EXCLUSION OF HEALTH CARE PROFESSIONALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

SEC. 913. (a) Part A of title XI of the Social Security Act is amended by inserting after section 1127 the following new section:

"EXCLUSION OF CERTAIN INDIVIDUALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

"SEC. 1128. (a) Whenever the Secretary determines that a physician or other individual has been convicted (on or after October 25, 1977, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such individual's participation in the delivery of medical care or services under title XVIII, XIX, or XX, the Secretary— 42 USC 1320a-7.

"(1) shall bar from participation in the program under title XVIII, for such period as he may deem appropriate, each such individual otherwise eligible to participate in such program; 42 USC 1395, 1396, 1397.

"(2)(A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX or title XX, of the fact and circumstances of such determination, and (except as provided in subpar- Notice.

agraph (B)) require each such agency to bar such individual from participation in such plan for such period as he shall specify, which in the case of an individual specified in paragraph (1) shall be the period established pursuant to paragraph (1);

Waiver

"(B) may waive the requirement under subparagraph (A) to bar an individual from participation in a State plan under title XIX or title XX, where he receives and approves a request for such a waiver with respect to that individual from the State agency administering or supervising the administration of such plan; and

42 USC 1396, 1397

Notice

"(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such individual of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.

"(b) A determination made by the Secretary under this section shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services furnished under title XVIII, such determination shall be effective in the manner provided in paragraphs (3) and (4) of section 1866(b) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

42 USC 1395.

42 USC 1395cc.

Notice and hearing.

"(c) Any person who is the subject of an adverse determination made by the Secretary under subsection (a) shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).".

42 USC 405.

42 USC 1395y.

(b) Section 1862(e) of such Act is amended to read as follows:

"(e) No payment may be made under this title with respect to any item or service furnished by a physician or other individual during the period when he is barred pursuant to section 1128 from participation in the program under this title.".

Ante, p. 2619.

42 USC 1396a.

(c) Section 1902(a)(39) of such Act is amended to read as follows:

"(39) provide that the State agency shall bar any specified individual from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1128, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual during such period;".

Repeal.

42 USC 1396a.

42 USC 1397b.

(d) Section 1902(g) of such Act is repealed.

(e) Section 2003(d)(1) of such Act is amended—

(1) by striking out "and" at the end of subparagraph (I),

(2) by striking out the period at the end of subparagraph (J) and inserting in lieu thereof "; and", and

(3) by inserting after subparagraph (J) the following new subparagraph:

"(K) provides that the State will bar any specified individual from participation in the program for the period specified by the Secretary when required by him to do so pursuant to section 1128, and provides that no payment may be made under the program with respect to any item or service furnished by such individual during such period.". *Ante*, p. 2619.

COORDINATED AUDITS UNDER THE SOCIAL SECURITY ACT

SEC. 914. (a) Title XI of the Social Security Act is amended by inserting after section 1128 (added by section 913(a) of this title the following new section:

"COORDINATED AUDITS

"SEC. 1129. (a) If an entity provides services reimbursable on a cost-related basis under title V or XIX, as well as services reimbursable on such a basis under title XVIII, the Secretary shall require, as a condition for payment to any State under title V or XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of title XVIII. The Secretary shall specify by regulation such methods as he finds feasible and equitable for the apportionment of the cost of coordinated audits between the program established under title V or XIX and the program established under title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to title V or XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be in excess of the amount that would have been apportioned to the State under the title (for the expenses of the Sate incurred in the common audit) if it had participated in the common audit. 42 USC 1320a-8. 42 USC 701, 1396. 42 USC 1395.

"(b)(1) In the case of entities which have audits coordinated under subsection (a), the Secretary shall establish one or more projects to demonstrate the feasibility of creating a single coordinated appeal hearing to adjudicate those administrative cost items which are determined under such a coordinated audit and which such entities dispute and appeal. Demonstration projects.

"(2) In the case of a demonstration project under this subsection, the Secretary may waive such requirements of title V, XVIII, or XIX as would prevent carrying out the project or would require duplicative activity or otherwise create unnecessary administrative burdens in carrying out the project. Waiver.

"(3) The Secretary shall report to Congress not later than December 31, 1982, with respect to demonstration projects conducted under this subsection, including the reaction of the entities involved and estimates of any savings effected through reduction of duplication of appeal hearings, and shall include in such report recommendations for such legislation as the Secretary deems appropriate to insure the maximum feasible coordination of such appeal hearings. Report to Congress.

"(4) The Secretary shall also provide for the review of the feasibility of establishing a single coordinated process for the collection of overpayments established in a coordinated audit under subsection (a). The Secretary shall report to Congress not later than December 31, 1981, on such review and on such recommendations for changes in legislation as the Secretary deems appropriate.". Review, report to Congress.

(b)(1) Section 1902(a) of such Act is amended— 42 USC 1396a.

(A) by striking out "and" at the end of paragraph (40);

(B) by striking out the period at the end of paragraph (41) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (41) the following new paragraph:

"(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1129(a).".

42 USC 1395.

Ante, p. 2621.

(2)(A) The amendments made by paragraph (1) shall (except as provided under subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after the first day of the first calendar quarter beginning more than 30 days after the date of the enactment of this Act.

42 USC 1396a note.

42 USC 1396.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

42 USC 705.

(c)(1) Section 505(a) of such Act is amended--

(A) by striking out "and" at the end of paragraph (14);

(B) by striking out the period at the end of paragraph (15) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (15) the following new paragraph:

"(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1129(a).".

42 USC 1395.

42 USC 705 note.

(2) The amendments made by paragraph (1) shall apply to services provided, under a State plan approved under title V of the Social Security Act, on and after the first day of the first calendar quarter beginning more than 30 days after the date of the enactment of this Act.

42 USC 701.

Report to Congress.

(d) The Secretary shall report to the Congress, not later than December 31, 1981, on actions the Secretary has taken (1) to coordinate the conduct of institutional audits and inspections which are required under the programs funded under title V, XVIII, or XIX of the Social Security Act, and (2) to coordinate such audits and inspections with those conducted by other cost payers, and he shall include in such report recommendations for such legislation as he

42 USC 1320a-8 note.

42 USC 701, 1395, 1396.

deems appropriate to assure the maximum feasible coordination of such institutional audits and inspections.

LIFE SAFETY CODE REQUIREMENTS

SEC. 915. (a) Section 1861(j)(13) of the Social Security Act is amended by striking out "the Life Safety Code of the National Fire Protection Association (23d edition, 1973)" and inserting in lieu thereof "such edition (as is specified by the Secretary in regulations) of the Life Safety Code of the National Fire Protection Association". 42 USC 1395x.

(b) Any institution (or part of an institution) which complied with the requirements of section 1861(j)(13) of the Social Security Act on the day before the date of the enactment of this Act shall, so long as such compliance is maintained (either by meeting the applicable provisions of the Life Safety Code (21st edition, 1967, or 23d edition, 1973), with or without waivers of specific provisions, or by meeting the applicable provisions of a fire and safety code imposed by State law as provided for in such section 1861(j)(13)), be considered (for purposes of titles XVIII or XIX of such Act) to be in compliance with the requirements of such section 1861(j)(13), as it is amended by subsection (a) of this section. 42 USC 1395x note. 42 USC 1395, 1396.

ALTERNATIVE TO DECERTIFICATION OF LONG-TERM CARE FACILITIES OUT OF COMPLIANCE WITH CONDITIONS OF PARTICIPATION; LOOK BEHIND AUTHORITY

SEC. 916. (a) Section 1866 of the Social Security Act is amended by adding at the end thereof the following new subsection: 42 USC 1395cc.

"(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which has been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies— 42 USC 1396. 42 USC 1395x.

"(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

"(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act to deny payment under such title XIX) with respect to any individual admitted to such facility after a date specified by him. 42 USC 1396a.

"(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing. Notice and hearing.

"(3) The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j), or (B) in the case described in Notice.

paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of section 1861(j) on the date specified in such clause, the Secretary shall terminate such facility's agreement or provide for termination of such facility's certification, notwithstanding the provisions of paragraph (2) of subsection (b), effective with the first day of the first month following the month specified in such clause.".

42 USC 1395x.

42 USC 1396a

(b)(1)(A) Section 1902 of such Act is amended by adding after subsection (h) (added by section 902(b)(2) of this title) the following new subsection:

"(i)(1) In addition to any other authority under State law, where a State determines that a skilled nursing facility or intermediate care facility which is certified for participation under its plan no longer substantially meets the provisions of section 1861(j) or section 1905(c), respectively, and further determines that the facility's deficiencies—

42 USC 1396d.

"(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

"(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

Notice and hearing.

"(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j) or section 1905(c) (as the case may be), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

"(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j) or section 1905(c) (as the case may be), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.".

(B) Such section is further amended by inserting before the semicolon at the end of subsection (a)(33)(B) the following: ", except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation".

42 USC 1396i.

(2) Section 1910 of such Act is amended by adding at the end thereof the following new subsection:

"(c)(1) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds on the basis of a

determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur. 42 USC 1396a. 42 USC 1396d. 42 USC 1395cc. 42 USC 1395.

"(2) Any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.". Hearing and judicial review. 42 USC 405.

CRIMINAL STANDARDS FOR CERTAIN MEDICARE- AND MEDICAID-RELATED CRIMES

SEC. 917. Paragraphs (1) and (2) of section 1877(b) of the Social Security Act and of section 1909(b) of such Act are each amended by inserting "knowingly and willfully" after "Whoever". 42 USC 1395nn, 1396h.

REIMBURSEMENT OF CLINICAL LABORATORIES

SEC. 918. (a)(1) Section 1842 of the Social Security Act is amended by inserting at the end the following new subsection: 42 USC 1395u.

"(h) If a physician's bill or request for payment for a physician's services includes a charge to a patient for a laboratory test for which payment may be made under this part, the amount payable with respect to the test shall be determined as follows:

"(1) If the bill or request for payment indicates that the physician who submitted the bill or for whose services the request for payment was made personally performed or supervised the performance of the test or that another physician with whom the physician shares his practice personally performed or supervised the test, the payment shall be the reasonable charge for the test (less the applicable deductible and coinsurance amounts).

"(2) If the bill or request for payment indicates that the test was performed by a laboratory, identifies the laboratory, and indicates the amount the laboratory charged the physician who submitted the bill or for whose services the request for payment was made, payment for the test shall be the lower of—

"(A) the laboratory's reasonable charge to individuals enrolled under this part for the test, or

"(B) the amount the laboratory charged the physician for the test,

plus a nominal fee (where the physician bills for such a service) to cover the physician's costs in collecting and handling the sample on which the test was performed (less the applicable deductible and coinsurance amounts).

"(3) If the bill or request for payment (A) does not indicate who performed the test, or (B) indicates that the test was performed by a laboratory but does not identify the laboratory or include the amount charged by the laboratory, payment shall be the lowest charged at which the carrier estimates the test could have been secured by a physician from a laboratory serving the locality (less the applicable deductible and coinsurance amounts).".

Publication in Federal Register. 42 USC 1395u note.

(2) The amendment made by paragraph (1) shall apply to bills submitted and requests for payment made on or after such date (not later than April 1, 1981) as the Secretary of Health and Human Services prescribes by a notice published in the Federal Register.

Report to Congress. 42 USC 1395u note.

(3) Not later than 24 months after the effective date specified in paragraph (2), the Secretary shall report to the Congress—

(A) the proportion of bills and requests for payment submitted (during the 18-month period beginning on such effective date) under title XVIII of the Social Security Act for laboratory tests which did not identify who performed the tests,

42 USC 1801.

(B) the proportion of bills and requests for payment submitted during such period for laboratory tests with respect to which the amount paid under such title was less than the amount that would otherwise have been payable in the absence of section 1842(h) of such Act,

Ante, p. 2625.

(C) with respect to requests for payment described in subparagraph (B) which were submitted by patients, the average additional cost per laboratory test to patients resulting from reductions in payment that would otherwise have been made for such tests in the absence of such section 1842(h), and

(D) with respect to bills described in subparagraph (B) which were submitted by physicians, the average reduction in payment per laboratory test to physicians resulting from the application of such section 1842(h).

42 USC 1395*l*.

(4) Section 1833(a)(1)(D) of the Social Security Act is amended by striking out "subsection (g)" and inserting in lieu thereof "subsection (h)".

42 USC 1396a.

(b)(1) Section 1902(a) of the Social Security Act (as amended by section 914(b)(1) of this Act) is further amended—

(A) by striking out "and" at the end of paragraph (41);

(B) by striking out the period at the end of paragraph (42) and inserting in lieu thereof "; and"; and

(C) by adding after paragraph (42) the following new paragraph:

"(43) if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician (or any other physician with whom he shares his practice) did not personally perform or supervise, include provision to insure that payment under the State plan for such laboratory services not exceed the payment authorized for such services by section 1842(h).".

42 USC 1396a note.

(2)(A) The amendments made by paragraph (1) shall (except as otherwise provided in subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social

Security Act, on and after the first day of the first calendar quarter that begins more than six months after the date of the enactment of this Act. 42 USC 1396.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

STUDY OF NEED FOR DUAL PARTICIPATION OF SKILLED NURSING FACILITIES

SEC. 919. (a)(1) The Secretary of Health and Human Services shall conduct a study of the availability and need for skilled nursing facility services covered under part A of title XVIII of the Social Security Act and under State plans approved under title XIX of such Act. 42 USC 1395b-1 note. 42 USC 1395. 42 USC 1396.

(2) Such study shall include— Contents.

(A) an investigation of the desirability and feasibility of imposing a requirement that skilled nursing facilities (i) which furnish services to patients covered under State plans approved under title XIX of the Social Security Act also furnish such services to patients covered under part A of title XVIII of such Act, and (ii) which furnish services to patients covered under such title XVIII also furnish such services to patients covered under such State plans,

(B) an evaluation of the impact of existing laws and regulations on skilled nursing facilities and individuals covered under such State plans and under part A of such title XVIII, and an evaluation of the extent to which existing laws and regulations encourage skilled nursing facilities to accept only title XVIII beneficiaries or title XIX recipients, and

(C) an investigation of possible changes in regulations and legislation which would result in encouraging a greater availability of skilled nursing facility services.

(3) In developing such study, the Secretary shall consult with professional organizations, health experts, private insurers, nursing home providers, and consumers of skilled nursing facility services. Consultation.

(b) Within one year after the date of the enactment of this Act, the Secretary shall complete such study and shall submit to the Congress a full and complete report thereon, together with recommendations with respect to the matters covered by such study (including any recommendations for administrative or legislative changes). Report to Congress.

Subpart III—Provisions Relating to Professional Standards Review Organizations (PSROs)

EXPANDED MEMBERSHIP OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 921. Section 1152(b)(1)(A) of the Social Security Act is amended— 42 USC 1320c-1.

(1) by inserting "and, if the organization so elects, of other health care practitioners engaged in the practice of their professions in such area who hold independent hospital admitting privileges," after the comma at the end of clause (ii); and

(2) by inserting "(except as otherwise provided under section 1155(c))" after "does not" in clause (vi).

42 USC 1320c-4

REGISTERED NURSE AND DENTIST MEMBERSHIP ON STATEWIDE COUNCIL ADVISORY GROUP

42 USC 1320c-11

SEC. 922. (a) Section 1162(e)(1) of the Social Security Act is amended by inserting "(including at least one registered professional nurse and at least one doctor of dental surgery or of dental medicine)" after "representatives".

Effective date. 42 USC 1320c-11 note.

(b) The amendment made by this section shall become effective 180 days after the date of the enactment of this Act.

NONPHYSICIAN MEMBERSHIP ON NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

42 USC 1320c-12.

SEC. 923. (a) Section 1163(a)(1) of the Social Security Act is amended by inserting "one doctor of dental surgery or of dental medicine, one registered professional nurse, and one other health practitioner (other than a physician as defined in section 1861(r)(1))," after "physicians,".

42 USC 1395x.

(b) Section 1163(a)(2) of such Act is amended by striking out "four members" and inserting in lieu thereof "five members".

(c) Section 1163(a)(3) of such Act is amended by inserting "physician" before "members".

(d) Section 1163(b) of such Act is amended by striking out "Members" and inserting in lieu thereof "Physician members".

42 USC 1320c-22. 42 USC 1320c-4, 1320c-12.

(e) Section 1173 of such Act is amended by striking out "(except sections 1155(c) and 1163)" and inserting in lieu thereof "(except section 1155(c))".

42 USC 1320c-12 note.

(f) The amendments made by this section shall become effective 180 days after the date of the enactment of this Act.

REQUIRED ACTIVITIES OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

42 USC 1320c-3.

SEC. 924. (a)(1) Subsection (b) of section 1154 of the Social Security Act is amended—

(A) by striking out "in addition to review of health care services provided by or in institutions, only such of the duties and functions required under this part of Professional Standards Review Organization as he determines such organization to be capable of performing" in the first sentence and inserting in lieu thereof "in addition to review of health care services (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals and to review of alcohol detoxification facility services, only such of the duties and functions as he requires the organization to perform under subsection (f)(2) or subsection (f)(4) and which the organization is capable of performing"; and

(B) by striking out "only if the Secretary finds that it is substantially carrying out in a satisfactory manner, the activities and functions required of Professional Standards Review Organizations under this part with respect to the review of health care services provided by or in institutions (including ancillary serv-

ices) and, in addition, review of such other health care services as the Secretary may require" in the second sentence and inserting in lieu thereof "only if the Secretary finds that it is substantially carrying out in a satisfactory manner the activities and functions required of that Professional Standards Review Organization under this part".

(2) Subsection (c) of such section is amended by inserting "of that organization" after "required under this part".

(3) Such section if further amended by adding at the end the following new subsection:

"(f)(1) The Secretary shall establish a program (hereinafter in this subsection referred to as the 'program') for the evaluation of the cost-effectiveness of review of particular health care services by Professional Standards Review Organizations. Review program.

"(2) In order to demonstrate the cost-effectiveness of requiring review of particular health care services before such review is generally required, the program shall be designed in a manner so that the Secretary will require particular Professional Standards Review Organizations, chosen by a statistically valid method that will permit a valid evaluation of the cost-effectiveness of such review, to review particular health care services.

"(3) The program shall provide for the evaluation of cost-effectiveness of the review of particular health care services under the program, particularly in comparison with areas in which such review was not required or performed.

"(4) Based upon such evaluation, or upon an evaluation of comparable statistical validity, and a finding that review of particular health care services is cost-effective or yields other significant benefits, the Secretary shall specify such particular health care services which Professional Standards Review Organizations (either generally or under such conditions and circumstances as the Secretary may specify) have the duty and function of reviewing under this part.

"(5) For purposes of this subsection, the term 'particular health care services' does not include health care services (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals or alcohol detoxification facility services.". "Particular health care services."

(b) Section 1155(a) of such Act is amended— 42 USC 1320c-4.

(1) by striking out "at the earliest date practicable" in paragraph (1) and inserting in lieu thereof "to the extent and at the time specified by the Secretary under section 1154(f)"; *Ante*, p. 2628.

(2) by inserting ", consistent with section 1154(f)," in paragraph (7)(A) after "only"; and

(3) by inserting "(consistent with section 1154(f))" in paragraph (7)(B) after "to the extent".

(c) Subsection (g) of section 1155 of such Act is repealed. Repeal.

(d) Section 1155 of such Act is amended by adding at the end thereof the following new subsection: 42 USC 1320c-4.

"(h) If the Secretary has designated an organization (other than under section 1154) as a Professional Standards Review Organization, but that organization has not assumed responsibility for the review of particular activities in its area included in subsection (a)(1), the Secretary may designate another qualified Professional Standards Review Organization (in reasonable proximity to the providers and practitioners whose services are to be reviewed) to assume the responsibility for the review of some or all of those particular activities.". 42 USC 1320c-3.

EFFICIENCY IN DELEGATED REVIEW

42 USC 1320c-4.

SEC. 925. Section 1155(e) of the Social Security Act is amended by striking out "effectively and in timely fashion" and inserting in lieu thereof "effectively, efficiently, and in timely fashion".

REVIEW OF ROUTINE HOSPITAL ADMISSION SERVICES AND PREOPERATIVE HOSPITAL STAYS BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

42 USC 1320c-4.

SEC. 926. Section 1155(a)(2) of the Social Security Act is amended to read as follows:

"(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

"(A) any elective admission to a hospital or other health care facility (including admissions occurring on weekends), and

"(B) any routine diagnostic services furnished in connection with such an admission,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in subparagraphs (A) and (C) of paragraph (1). Each such Organization may be directed by the Secretary to excercise such authority where the Secretary finds (consistent with section 1154(f)) that such determinations can be made on a timely basis by the Organization and appropriate procedures will be applied to assure prompt notification of such determinations to providers, physicians, practitioners, and persons on whose behalf payment may be made under this Act for services and items.".

Ante, p. 2628.

CONSULTATION BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS WITH HEALTH CARE PRACTITIONERS

42 USC 1320c-4.

SEC. 927. (a) Section 1155(a) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(8) Each Professional Standards Review Organization shall consult (with such frequency and in such manner as may be prescribed by the Secretary) with representatives of health care practitioners (other than physicians described in section 1861(r)(1)) and of institutional and noninstitutional providers of health care services, in relation to the Professional Standards Review Organization's responsibility for the review under paragraph (1) of the professional activities of such practitioners and providers.".

42 USC 1395x.

42 USC 1320c-11.

(b) Section 1162(e) of such Act is amended by striking out the first parenthetical material in paragraph (1) and the parenthetical material in paragraph (2).

Effective date. 42 USC 1320c-4 note.

(c) The amendments made by this section shall become effective 180 days after the date of the enactment of this Act.

RESPONSE OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS TO FREEDOM OF INFORMATION ACT REQUESTS

42 USC 1320c-15 note.

42 USC 1320c.

SEC. 928. No Professional Standards Review Organization designated (conditionally or otherwise) under part B of title XI of the Social Security Act shall be required to make available any records pursuant to a request made under section 552 of title 5, United States Code, until the later of (1) one year after the date of entry of a final court order requiring that such records be made available, or (2) the last date of the Congress during which the court order was entered.

STUDY OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS NORMS, STANDARDS, AND CRITERIA

SEC. 929. The Secretary of Health and Human Services shall, in consultation with the National Professional Standards Review Council, conduct a nationwide study of the differences in medical criteria and length-of-stay norms utilized by Professional Standards Review Organizations in the various regions of the country. The study shall include an assessment of the rationale that contributes to these regional differences. The Secretary shall report the findings and conclusions made with respect to the study to the Congress within one year after the date of the enactment of this Act. 42 USC 1320c note. Report to Congress.

PART B—PROVISIONS RELATING TO MEDICARE

Subpart I—Changes in Services or Benefits

HOME HEALTH SERVICES

SEC. 930. (a) Section 1811 of the Social Security Act is amended by striking out "and related post-hospital services" and inserting in lieu thereof ", related post-hospital, and home health services". 42 USC 1395c.

(b) Section 1812(a)(3) of such Act is amended to read as follows: 42 USC 1395d.
"(3) home health services.".

(c) Section 1812(d) of such Act is repealed. Repeal.

(d) Section 1812(e) of such Act is amended—
(1) by striking out "(b), (c), and (d)" and inserting in lieu thereof "(b) and (c)"; and
(2) by striking out "post-hospital extended care services, and post-hospital home health services" and inserting in lieu thereof "and post-hospital extended care services".

(e) Sections 1814(a) and 1835(a) of such Act are amended by adding the following new sentence at the end of each such section: "With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractural relationship with, such home health agency from performing such certification and from establishing or reviewing such plan.". Regulations. 42 USC 1395f, 1395n.

(f) Section 1814(a)(2)(D) of such Act is amended— 42 USC 1395f.
(1) by striking out "post-hospital home health services" and inserting in lieu thereof "home health services";
(2) by inserting ", occupational," after "or physical"; and
(3) by striking out ", for any of the conditions" and all that follows through "extended care services".

(g) Section 1832(a)(2)(A) of such Act is amended by striking out "for up to 100 visits during a calendar year". 42 USC 1395k.

(h) Section 1833(b) of such Act is amended— 42 USC 1395l.
(1) by striking out "and" at the end of clause (1) in the first sentence; and
(2) by inserting before the period at the end of the first sentence the following: ", (3) such deductible shall not apply with respect to home health services".

(i) Section 1834 of such Act is repealed. Repeal. 42 USC 1395m.

42 USC 1395m

(j) Section 1835(a)(2)(A) of such Act is amended by inserting ", occupational," after "or physical".

42 USC 1395x

(k) Section 1861(e) of such Act is amended—

(1) by striking out "subsections (i) and (n)" in the material preceding paragraph (1) and inserting in lieu thereof "subsection (i)", and

(2) by striking out "subsections (i) and (n)" in the third sentence and inserting in lieu thereof "subsection (i)".

(l) Section 1861(m)(4) of such Act is amended by inserting the following before the semicolon: "who has successfully completed a training program approved by the Secretary".

Repeal.

(m) Section 1861(n) of such Act is repealed.

(n) Section 1861(o) of such Act is amended—

(1) by striking out "and" at the end of paragraph (5), by inserting "and" at the end of paragraph (6), and by adding the following new paragraph after paragraph (6):

"(7) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program;"; and

(2) by striking out "except that" the first place it appears in the material following paragraph (6) and all that follows through "regulations; and"

42 USC 1395h.

(o) Section 1816(e) of such Act is amended—

(1) by inserting "(subject to the provisions of paragraph (4))" after "the Secretary may" in paragraph (2); and

(2) by adding the following new paragraph at the end thereof:

"(4) Notwithstanding subsections (a) and (d) and paragraphs (1), (2), and (3) of this subsection, the Secretary shall designate regional agencies or organizations which have entered into an agreement with him under this section to perform functions under such agreement with respect to home health agencies (as defined in section 1861(o)) in the region, except that in assigning such agencies to such designated regional agencies or organizations the Secretary shall assign a home health agency which is a subdivision of a hospital (and such agency and hospital are affiliated or under common control) only if, after applying such criteria relating to administrative efficiency and effectiveness as he shall promulgate, he determines that such assignment would result in the more effective and efficient administration of this title.".

42 USC 1395x.

(p) Section 1861(v)(1) of such Act is amended by adding after subparagraph (G) (as added by section 902(a)(1) of this title) the following new subparagraph:

Reasonable costs, determination.

"(H) In determining such reasonable cost with respect to home health agencies, the Secretary may not include—

"(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of the financial security requirement described in subsection (o)(7);

"(ii) in the case of home health agencies to which the financial security requirement described in subsection (o)(7) applies, any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this title to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

"(iii) in the case of contracts entered into by a home health agency after the date of the enactment of this subparagraph for

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the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract (I) which is entered into for a period exceeding five years, or (II) which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency; and

"(iv) in the case of contracts entered into by a home health agency before the date of the enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract, which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency, to the extent that such cost exceeds the reasonable value of the services furnished on behalf of such agency.".

(q) Section 226(c)(1) of such Act is amended— 42 USC 426.

(1) by striking out "and post-hospital home health services" and inserting in lieu thereof "and home health services"; and

(2) by striking out "or post-hospital home health services" in clause (B).

(r) Section 7(d)(1) of the Railroad Retirement Act of 1974 is amended by striking out "posthospital home health services" and inserting in lieu thereof "home health services". 45 USC 231f.

(s)(1) the amendments made by this section shall become effective with respect to services furnished on or after July 1, 1981, except that the amendments made by subsections (n)(1) and (o) shall become effective on the date of the enactment of this Act. 42 USC 1395x note.

(2) The Secretary of Health and Human Services shall take administrative action to assure that improvements, in accordance with the amendment made by subsection (n)(1), will be made not later than June 30, 1981.

ALCOHOL DETOXIFICATION FACILITY SERVICES

SEC. 931. (a) Section 1812(a) of the Social Security Act is amended by striking out "and" at the end of paragraph (2), by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; and", and by adding after paragraph (3) the following new paragraph: 42 USC 1395d.

"(4) alcohol detoxification facility services.".

(b) Section 1814(a)(2) of such Act is amended by striking out "or" at the end of subparagraph (D), by inserting "or" at the end of subparagraph (E), and by adding after subparagraph (E) the following new subparagraph: 42 USC 1395f.

"(F) in the case of alcohol detoxification facility services, such services are required on an inpatient basis (based upon an examination by such certifying physician made prior to initiation of alcohol detoxification);".

(c) Section 1861(u) of such Act is amended by inserting "detoxification facility," after "home health agency,". 42 USC 1395x.

(d) Section 1861 of such Act is further amended by adding after subsection (aa) the following new subsection:

"Alcohol Detoxification Facility Services

"(bb)(1) The term 'alcohol detoxification facility services' means services provided by a detoxification facility in order to reduce or

eliminate the amount of alcohol in the body, but only to the extent that such services would be covered under subsection (b) if furnished as inpatient services by a hospital, or are physicians' services covered under subsection (s).

"(2) The term 'detoxification facility' means a public or voluntary community-based nonprofit facility, other than a hospital, which—

"(A) is engaged in furnishing to inpatients the services described in paragraph (1);

"(B) is accredited by the Joint Commission on the Accreditation of Hospitals as meeting the Accreditation Program for Psychiatric Facilities standards (1979 edition), or is found by the Secretary to meet such standards;

"(C) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring services not available at the facility; and

42 USC 1395cc.

"(D) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by the facility.".

Effective date.
42 USC 1395d note.

(e) The amendments made by subsections (a) through (d) of this section shall become effective on April 1, 1981.

Study.
42 USC 1395 *ll* note.

(f) The Secretary of Health and Human Services shall conduct a study and make recommendations, within 18 months after the date of the enactment of this Act, concerning the appropriateness of extending medicare coverage to drug detoxification, postdetoxification rehabilitation, and to outpatient detoxification and concerning incentives for the use of lower-cost detoxification facilities.

42 USC 1320c-4.

(g) Section 1155 of the Social Security Act is amended by adding after subsection (h) (added by section 924(d) of this title) the following new subsection:

"(i) Any Professional Standards Review Organization which has assumed responsibility under this section for review of inpatient hospital services in an area shall also assume responsibility in such area for review of detoxification facility services.".

42 USC 1320c-7.

(h) Section 1158 of such Act is amended—

(1) by striking out "section 1159 and subsection (d)" in subsection (a) and inserting in lieu thereof "subsections (d) and (e) of this section and in sections 1159, 1861(v)(1)(G), and 1902(h)", and

(2) by adding after subsection (d) the following new subsection:

"(e) Subsection (a) of this section shall not apply to a determination by a Professional Standards Review Organization under section 1155(a)(1)(C) that detoxification services provided or proposed to be provided in a hospital on an inpatient basis could be more economically provided in a detoxification facility.".

42 USC 1320c-4.

PREADMISSION DIAGNOSTIC TESTING

42 USC 1395*l*.

SEC. 932. (a)(1) Section 1833(a)(1) of the Social Security Act is amended—

(A) by striking out "and (E)" and inserting in lieu thereof "(E)", and

(B) by inserting the following after "section 1881," at the end of clause (E): "(F) with respect to expenses incurred for physicians' services (furnished by a physician who has an agreement in effect with the Secretary by which the physician agrees to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all physicians' services which are preadmission diagnostic services furnished by the physician to individuals

42 USC 1395u.

enrolled under this part) which are preadmission diagnostic services for which payment may be made under this part and which are furnished (i) in the outpatient department of a hospital within seven days of such individual's admission to the same hospital as an inpatient or, to the extent practicable as determined by regulations prescribed by the Secretary, to another hospital, or (ii) to the extent practicable as determined by regulations prescribed by the Secretary, in a physician's office within seven days of such individual's admission to a hospital as an inpatient, the amounts paid shall be equal to the reasonable charges for such services,".

(2) For amendment to section 1833(a) of the Social Security Act, with respect to the amount of payment for hospital outpatient preadmission diagnostic services, see section 942 of this title.

(b) The Secretary of Health and Human Services shall transmit to the Congress, no later than one year after the date of the enactment of this Act, a report describing the policy which has been developed and is being or will be implemented with respect to the amendments made by subsection (a)(1) of this section and by section 942 of this title as they concern expenses incurred for preadmission diagnostic testing furnished to an individual at a hospital within seven days of an individual's admission to another hospital. Report to Congress. 42 USC 1395l note.

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES

SEC. 933. (a) Section 1832(a)(2) of the Social Security Act is amended by striking out "and" at the end of subparagraph (C), by striking out the period at the end of subparagraph (D) and inserting in lieu thereof a semicolon, and by adding the following new subparagraph at the end thereof: 42 USC 1395k.

"(E) comprehensive outpatient rehabilitation facility services; and".

(b) Section 1835(a)(2) of such Act is amended by striking out the period at the end of subparagraph (D) and inserting in lieu thereof a semicolon, and by inserting the following new subparagraph after subparagraph (D): 42 USC 1395m.

"(E) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; and".

(c) Section 1861(u) of such Act is amended by inserting "comprehensive outpatient rehabilitation facility," immediately after "skilled nursing facility,". 42 USC 1395x.

(d) Section 1861(z) of such Act is amended by striking out "extended care facility," and inserting in lieu thereof "skilled nursing facility, comprehensive outpatient rehabilitation facility,".

(e) Section 1861 of such Act is amended by adding after subsection (bb) (added by section 931(d) of this title) the following new subsection:

"Comprehensive Outpatient Rehabilitation Facility Services

"(cc)(1) The term 'comprehensive outpatient rehabilitation facility services' means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of

a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

"(A) physicians' services;

"(B) physical therapy, occupational therapy, speech pathology services, and respiratory therapy;

"(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

"(D) social and psychological services;

"(E) nursing care provided by or under the supervision of a registered professional nurse;

"(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self administered;

"(G) supplies, appliances, and equipment, including the purchase or rental of equipment; and

"(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an outpatient of a hospital.

"(2) The term 'comprehensive outpatient rehabilitation facility' means a facility which—

"(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons;

"(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians, as defined in section 1861(r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

42 USC 1395x.

"(C) maintains clinical records on all patients;

"(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

"(E) has a requirement that every patient must be under the care of a physician;

"(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standard establishment for such licensing;

"(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

"(H) has in effect an overall plan and budget that meets the requirements of subsection (z); and

"(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.".

42 USC 1395z.

(f) Section 1863 of such Act is amended by striking out "and (o)(6)" in the first sentence and inserting in lieu thereof "(o)(6), and (cc)(2)(I)".

(g) Section 1864(a) of such Act is amended— 42 USC 1395aa.

(1) by inserting "or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc)(2)" after "section 1861(aa)(2)" in the first sentence; and *Ante*, p. 2635.

(2) by inserting "comprehensive outpatient rehabilitation facility," after "rural health clinic," each place it appears in the second and fifth sentences.

(h) The amendments made by this section shall become effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period which begins on or after July 1, 1981. 42 USC 1395k note.

OUTPATIENT SURGERY

SEC. 934. (a) Section 1832(a)(2) of the Social Security Act is amended by adding after subparagraph (E) (added by section 933(a) of this title) the following new subparagraph: 42 USC 1395k.

"(F) facility services furnished in connnection with surgical procedures specified by the Secretary—

"(i) pursuant to section 1833(i)(1)(A) and performed in an ambulatory surgical center (which meets health, safety, and other standards specified by the Secretary in regulations) if the center has an agreement in effect with the Secretary by which the center agrees to accept the amount determined under section 1833(i)(2)(A) as full payment for such services and to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all such services furnished by the center to individuals enrolled under this part, or *Infra.* 42 USC 1395u.

"(ii) pursuant to section 1833(i)(1)(B) and performed by a physician, described in section 1861(r)(1), in his office, if the Secretary has determined that— *Infra.* 42 USC 1395x.

"(I) a Professional Standards Review Organization (designated, conditionally or otherwise, under part B of title XI of this Act) is willing, able, and has agreed to carry out a review (on a sample or other reasonable basis) of the physician's performing such procedures in the physician's office, 42 USC 1320c.

"(II) the particular physician involved has agreed to make available to such Organization such records as the Secretary determines to be necessary to carry out the review, and

"(III) the physician is authorized to perform the procedure in a hospital located in the area in which the office is located,

and if the physician agrees to accept the amount determined under section 1833(i)(2)(B) as full payment for such services and to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with such surgical procedure to individuals enrolled under this part.". *Infra.* 42 USC 1395u. 42 USC 1395x.

(b) Section 1833 of such Act is amended by adding at the end the following new subsection: 42 USC 1395*l*.

"(i)(1) The Secretary shall, in consultation with the National Professional Standards Review Council and appropriate medical organizations—

"(A) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center (meeting the standards specified under section 1832(a)(2)(F)(i)) or hospital outpatient department, and

Ante, p. 2637.

"(B) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in a physician's office.

"(2)(A) The amount of payment to be made for facility services furnished in connection with a surgical procedure specified pursuant to paragraph (1)(A) and furnished to an individual in an ambulatory surgical center described in such paragraph shall be equal to a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

"(i) takes into account the costs incurred by such centers, or classes of centers, generally in providing services furnished in connection with the performance of such procedure, and

"(ii) takes such costs into account in such a manner as will assure that the performance of the procedure in such a center will result in substantially less amounts paid under this title than would have been paid if the procedure had been performed on an inpatient basis in a hospital.

Each amount so established shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

"(B) The amount of payment to be made under this part for facility services furnished, in connection with a surgical procedure specified pursuant to paragraph (1)(B), in a physician's office shall be equal to a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

"(i) takes into account additional costs, not usually included in the professional fee, incurred by physicians in securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and

"(ii) takes such items into account in such a manner which will assure that the performance of such procedure in the physician's office will result in substantially less amounts paid under this title than would have been paid if the services had been furnished on an inpatient basis in a hospital.

Each amount so established shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

"(3) In the case of services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with surgical procedures (specified pursuant to paragraph (1) of this subsection) in a physician's office, an ambulatory surgical center described in such paragraph, or a hospital outpatient department, payment for such services shall be determined in accordance with subsection (a)(1)(G) if the physician accepts an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for such services.

42 USC 1395x.

42 USC 1395u

"(4)(A) The Secretary is authorized to provide by regulations that in the case of a surgical procedure, specified by the Secretary pursuant to paragraph (1)(A), performed in an ambulatory surgical center described in such paragraph, there shall be paid (in lieu of any amounts otherwise payable under this part) with respect to the facility services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to subparagraph (B), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

"(B) In implementing this paragraph, the Secretary shall establish with respect to each surgical procedure specified pursuant to paragraph (1)(A) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.".

(c)(1) Section 1863 of the Social Security Act is amended by inserting "or by ambulatory surgical centers under section 1832(a)(2)(F)(i)," after "section 1861,". 42 USC 1395z.

(2) Section 1864(a) of such Act is amended— *Ante*, p. 2637, 42 USC 1395x.

(A) by inserting before the period at the end of the first sentence the following: ", or whether an ambulatory surgical center meets the standards specified under section 1832(a)(2)(F)(i)"; and 42 USC 1395aa.

(B) by inserting "ambulatory surgical center," in the fifth sentence after "health care facility," each place it appears. *Ante*, p. 2637.

(d)(1) Section 1833(a)(1) of such Act, as amended by section 932(a)(1) of this title, is further amended by inserting after the comma at the end of clause (F) the following new clause: "and (G) with respect to expenses incurred for services described in subsection (i)(3) under the conditions specified in such subsection, the amounts paid shall be the reasonable charge for such services,". 42 USC 1395l.

(2) For an additional amendment to section 1833(a) of the Social Security Act with respect to the amount of payment for outpatient surgical procedures, see section 942 of this title.

(3) The first sentence of section 1833(b) of such Act, as amended by section 930(h) of this title, is further amended by adding before the period at the end the following: ", and (4) such total amount shall not include expenses incurred for services the amount of payment for which is determined under subsection (a)(1)(G) or under subsection (i)(2) or (i)(4)".

OUTPATIENT PHYSICAL THERAPY SERVICES

SEC. 935. (a) Section 1833(g) of the Social Security Act is amended by striking out "$100" and inserting in lieu thereof "$500". 42 USC 1395l.

(b) The amendment made by subsection (a) shall apply to expenses incurred in calendar years beginning with calendar year 1982. 42 USC 1395l note.

DENTISTS' SERVICES

SEC. 936. (a) Clause (2) of the first sentence of section 1861(r) of the Social Security Act is amended to read as follows: "(2) a doctor of dental surgery or of dental medicine who is legally authorized to 42 USC 1395x.

practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions,".

42 USC 1395f. (b) Section 1814(a)(2)(E) of such Act is amended to read as follows:

"(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services; or".

42 USC 1395y. (c) Section 1862(a)(12) of such Act is amended by inserting "or because of the severity of the dental procedure," after "clinical status".

42 USC 1395f note. (d) The amendments made by this section shall apply with respect to services provided on or after July 1, 1981.

OPTOMETRISTS' SERVICES

42 USC 1395x. Recommendations, submittal to Congress. SEC. 937. (a) Clause (4) of the first sentence of section 1861(r) of the Social Security Act is amended by striking out "but only with respect to establishing the necessity for prosthetic lenses," and inserting in lieu thereof "but only with respect to services related to the condition of aphakia,".

42 USC 1395ll note. (b) The Secretary of Health and Human Services shall submit to the Congress by January 1, 1982, legislative recommendations with respect to reimbursement under title XVIII of the Social Security Act for services furnished by optometrists in connection with cataracts and such other services which they are legally authorized to perform.

42 USC 1395. 42 USC 1395x note. (c) The amendment made by subsection (a) shall apply to services furnished on on after July 1, 1981.

ANTIGENS

42 USC 1395x. SEC. 938 (a). Section 1861(s)(2) of the Social Security Act is amended by striking out "and" at the end of subparagraph (E), by adding "and" after the semicolon at the end of subparagraph (F), and by inserting the following new subparagraph after subparagraph (F):

"(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;".

42 USC 1395x note. (b) The amendments made by subsection (a) shall apply to services furnished on or after January 1, 1981.

TREATMENT OF PLANTAR WARTS

42 USC 1395y. SEC. 939. (a) Section 1862(a)(13)(C) of the Social Security Act is amended by striking out ", warts,".

42 USC 1395y note. (b) The amendment made by subsection (a) shall apply with respect to services furnished on or after July 1, 1981.

Subpart II—Administrative Changes and Miscellaneous Provisions

PRESUMED COVERAGE PROVISIONS

SEC. 941. (a) Section 1814 of the Social Security Act is amended by striking out subsections (h) and (i) and by redesignating subsection (j) as subsection (h). 42 USC 1395f.

(b) Section 1814(c) of such Act is amended by striking out "subsection (j)" and inserting in lieu thereof "subsection (h)". 42 USC 1395f note.

(c) The amendments made by this section shall take effect on January 1, 1981.

PAYMENT TO PROVIDERS OF SERVICES

SEC. 942. Section 1833(a) of such Act is amended by striking out paragraphs (2) and (3) and inserting in lieu thereof the following: 42 USC 1395l.

"(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D), (E), and (F) of such section and in paragraph (5) of this subsection and unless otherwise specified in section 1881)— 42 USC 1395k. 42 USC 1395rr.

"(A) with respect to home health services, the reasonable cost of such services, as determined under section 1861(v); 42 USC 1395x.

"(B) with respect to other services (except those described in subparagraph (C) of this paragraph), the reasonable costs of such services, as so determined, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such costs; and 42 USC 1395cc.

"(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services; 42 USC 1395x.

"(3) in the case of services described in subparagraphs (D) and (E) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services exceed 80 percent of such costs; 42 USC 1395k. 42 USC 1395x. 42 USC 1395cc.

"(4) in the case of facility services described in subparagraph (F) of section 1832(a)(2), the applicable amount described in paragraph (2) of section 1833(i); and 42 USC 1395k. *Ante*, p. 2637.

"(5) in the case of preadmission diagnostic services described in section 1861(s)(2)(C) which are furnished to an individual by the outpatient department of a hospital within 7 days of such individual's admission to the same hospital as an inpatient or (to the extent practicable as determined by regulations prescribed by the Secretary) to another hospital, the reasonable costs for such services.". 42 USC 1395x.

LIMITATION ON PAYMENTS TO RADIOLOGISTS AND PATHOLOGISTS

SEC. 943. (a) Subsections (a)(1)(B) and (b)(2) of section 1833 of the Social Security Act are each amended by inserting after "pathology" the following: "who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(B)(ii)) for all physicians' services furnished by him to hospital inpatients enrolled under this part". 42 USC 1395l. 42 USC 1395u.

42 USC 1395*l*.

(b) The amendments made by subsection (a) shall apply to services furnished after the sixth calendar month beginning after the date of the enactment of this Act.

PHYSICIAN TREATMENT PLAN FOR SPEECH PATHOLOGY

42 USC 1395n.

SEC. 944. (a) Section 1835(a)(2)(D)(ii) of the Social Security Act is amended by inserting after "established" the following: "by a physician or by the speech pathologist providing such services".

42 USC 1395n note.

(b) The amendment made by subsection (a) shall apply to plans for furnishing services established on or after January 1, 1981.

REENROLLMENT AND OPEN ENROLLMENT IN PART B

Repeal. 42 USC 1395p.

SEC. 945. (a) Subsection (b) of section 1837 of the Social Security Act is repealed.

(b)(1) Subsection (e) of such section is amended to read as follows: "(e) There shall be a general enrollment period which is any period after the period described in subsection (d).".

(2) Subsection (g)(3) of such section is amended by striking out "the earlier of the then current" and all that follows through "subsection (e) of this section)" and inserting in lieu thereof "the month in which the individual files an application establishing such entitlement".

42 USC 1395q.

(c)(1) Section 1838(a)(2)(E) of such Act is amended by striking out "the July 1" and inserting in lieu thereof "the first day of the third month".

42 USC 1395r.

(2) The second sentence of subsection (d) of section 1839 of such Act is amended by striking out "who enrolls for the second time) (2)" and all that follows through "in which he enrolled for the second time" and inserting in lieu therof "who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the month after the month in which he reenrolled".

42 USC 1395p note.

(d) The amendments made by subsections (a), (b), and (c) shall apply to enrollments occurring on or after April 1, 1981.

42 USC 1395v.

(e) Section 1843 of the Social Security Act is amended by inserting "or during 1981," in subsections (a), (g)(1), and (h)(1) after "January 1, 1970," each place it appears.

DETERMINATION OF REASONABLE CHARGE

42 USC 1395u.

SEC. 946. (a) The third sentence of section 1842(b)(3) of the Social Security Act is amended by striking out "in which the bill is submitted or the request for payment is made" and inserting in lieu thereof "in which the service is rendered".

(b) Such section is further amended by striking out "and" at the end of subparagraph (D), by inserting "and" after the semicolon at the end of subparagraph (E), and by inserting after subparagraph (E) the following new subparagraph:

"(F) will take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year (ending on June 30) in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year;".

(c) The amendments made by subsections (a) and (b) shall become effective with respect to bills submitted or requests for payment made on or after July 1, 1981. 42 USC 1395u note.

SHORTENED PART B TERMINATION PERIOD FOR CERTAIN INDIVIDUALS WHOSE PREMIUMS MEDICAID HAS CEASED TO PAY

SEC. 947. (a) Section 1843(e) of the Social Security Act is amended by adding at the end thereof the following: "The coverage period under this part of any such individual who (in the last month of his coverage period attributable to the State agreement or in any of the following six months) files notice that he no longer wishes to participate in the insurance program established by this part, shall terminate at the close of the month in which the notice is filed.". 42 USC 1395v.

(b) The second sentence of section 1838(b) of such Act is amended by inserting "(except as otherwise provided in section 1843(e))" after "shall". 42 USC 1395q.

(c) Section 1843(g)(2) of such Act is amended— 42 USC 1395v.

(1) by adding "and" at the end of clause (A);

(2) by striking out ", and" at the end of clause (B) and inserting in lieu thereof a period; and

(3) by striking out clause (C).

(d) The amendments made by this section apply to notices filed after the third calendar month beginning after the date of the enactment of this Act. 42 USC 1395v note.

(e) The coverage period under part B of title XVIII of the Social Security Act of an individual whose coverage period attributable to a State agreement under section 1843 of such Act is terminated and who has filed notice before the end of the third calendar month beginning after the date of the enactment of this Act that he no longer wishes to participate in the insurance program established by part B of title XVIII shall terminate on the earlier of (1) the day specified in section 1838 without the amendments made by this section, or (2) (unless the individual files notice before the day specified in this clause that he wishes his coverage period to terminate as provided in clause (1)) the day on which his coverage period would terminate if the individual filed notice in the fourth calendar month beginning after the date of the enactment of this Act. 42 USC 1395v note. 42 USC 1395j. 42 USC 1395v. 42 USC 1395j. 42 USC 1395q.

REIMBURSEMENT OF PHYSICIANS' SERVICES IN TEACHING HOSPITALS

SEC. 948. (a)(1) Paragraph (7) of section 1861(b) of the Social Security Act is amended to read as follows: 42 USC 1395x.

"(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.".

(2) Section 1832(a)(2)(B)(i)(II) of such Act is amended by striking out ", unless either clause (A) or (B) of paragraph (7) of such section is met" and inserting in lieu thereof "where the conditions specified in paragraph (7) of such section are met". 42 USC 1395k.

(b) Section 1842(b) of the Social Security Act is amended by adding at the end the following new paragraph: 42 USC 1395u.

"(6)(A) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section

42 USC 1395x. *Ante*, p. 2643.

1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), the carrier shall not provide (except on the basis described in subparagraph (C)) for payment for such services under this part—

"(i) unless—

"(I) the physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which the payment is sought,

"(II) the services are of the same character as the services the physician furnishes to patients not entitled to benefits under this title, and

"(III) at least 25 percent of the hospital's patients (during a representative past period, as determined by the Secretary) who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) paid all or a substantial part of charges (other than nominal charges) imposed for such services; and

"(ii) to the extent that the amount of the payment exceeds the reasonable charge for the services (with the customary charge determined consistent with subparagraph (B)).

"(B) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

"(i) In the case of a physician who has a substantial practice outside the teaching setting, the carrier shall take into account the amounts the physician charges for similar services in the physician's outside practice.

"(ii) In the case of a physician who does not have a practice described in clause (i), if the hospital, its physicians, or other appropriate billing entity has established one or more schedules of charges which are collected for medical and surgical services, the carrier shall base payment under this title on the greater of—

"(I) the charges (other than nominal charges) which are most frequently collected in full or substantial part with respect to patients who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) of subparagraph (A)(i), or

"(II) the mean of the charges (other than nominal charges) which were collected in full or substantial part with respect to such patients.

"(C) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), if the conditions described in subclauses (I) and (II) of subparagraph (A)(i) are met and if the physician elects payment to be determined under this subparagraph, the carrier shall provide for payment for such services under this part on the basis of regulations of the Secretary governing reimbursement for the services of hospital-based physicians (and not on any other basis).".

42 USC 1395x note.

(c)(1) The amendments made by subsection (a) shall apply with respect to cost accounting periods beginning on or after October 1, 1978. A hospital's election under section 1861(b)(7)(A) of the Social Security Act (as administered in accordance with section 15 of Public Law 93-233) as of September 30, 1978, shall constitute such hospital's election under such section (as amended by subsection (a)(1)) on and after October 1, 1978, until otherwise provided by the hospital.

Ante, p. 2643. 42 USC 1395k, 1395x and note.

(2) The amendment made by subsection (b) shall apply with respect to cost accounting periods beginning on or after January 1, 1981. 42 USC 1395u note.

FLEXIBILITY IN APPLICATION OF STANDARDS TO RURAL HOSPITALS

SEC. 949. Section 1861(e) of the Social Security Act is amended by adding the following new sentence at the end thereof: "The term 'hospital' also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that— 42 USC 1395x.

"(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

"(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients, and (iii) if the Secretary has determined that because of the facility's waiver under this subparagraph the facility should limit its scope of services in order not to adversely affect the health and safety of the facility's patients, the facility is so limiting the scope of services it provides; and

"(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary may (i), waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.".

HOSPITAL TRANSFER REQUIREMENT FOR SKILLED NURSING FACILITY COVERAGE

42 USC 1395x.

SEC. 950. Section 1861(i) of the Social Security Act is amended—

(1) by striking out "14 days" each place it appears and inserting in lieu thereof "30 days"; and

(2) by striking out ", or (B) within 28 days" and all that follows through "he resides, or (C)" and inserting in lieu thereof ", or (B)".

CERTIFICATION AND UTILIZATION REVIEW BY PODIATRISTS

42 USC 1395x.

SEC. 951. (a) Section 1861(r)(3) of the Social Security Act is amended to read as follows: "(3) a doctor of podiatric medicine for the purposes of subsection (s) of this section but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them; and for the purposes of subsections (k) and (m) of this section and sections 1814(a) and 1835 but only if his performance of functions under subsections (k) and (m) and sections 1814(a) and 1835 is consistent with the policy of the institution or agency with respect to which he performs them and with the functions which he is legally authorized to perform,".

Ante, p. 2631, 42 USC 1395n.

42 USC 1395x.

(b) Section 1861(k)(2)(A) of such Act is amended by inserting after "two or more physicians" the following: "(of which at least two must be physicians described in subsection (r)(1) of this section)".

Effective date. 42 USC 1395x note.

(c) The amendments made by this section shall take effect on January 1, 1981.

ACCESS TO BOOKS AND RECORDS OF SUBCONTRACTORS

42 USC 1395x.

SEC. 952. Section 1861(v)(1) of the Social Security Act is amended by adding after subparagraph (H) (added by section 930(p) of this title) the following new subparagraph:

"(I) In determining such reasonable cost, the Secretary may not include any costs incurred by a provider with respect to any services furnished in connection with matters for which payment may be made under this title and furnished pursuant to a contract between the provider and any of its subcontractors which is entered into after the date of the enactment of this subparagraph and the value or cost of which is $10,000 or more over a twelve-month period unless the contract contains a clause to the effect that—

"(i) until the expiration of four years after the furnishing of such services pursuant to such contract, the subcontractor shall make available, upon written request to the Secretary, or upon request to the Comptroller General, or any of their duly authorized representatives, the contract, and books, documents and records of such subcontractor that are necessary to certify the nature and extent of such costs, and

"(ii) if the subcontractor carries out any of the duties of the contract through a subcontract, with a value or cost of $10,000 or more over a twelve-month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of four years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request to the Secretary, or upon request to the Comptroller General, or any of their duly authorized representatives, the subcontract, and books, documents and

records of such organization that are necessary to verify the nature and extent of such costs.

The Secretary shall prescribe in regulation criteria and procedures which the Secretary shall use in obtaining access to books, documents, and records under clauses required in contracts and subcontracts under this subparagraph.".

MEDICARE LIABILITY SECONDARY WHERE PAYMENT CAN BE MADE UNDER LIABILITY OR NO FAULT INSURANCE

SEC. 953. Section 1862(b) of the Social Security Act is amended— 42 USC 1395y.

(1) by inserting "or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance" before the period at the end of the first sentence;

(2) by inserting ", policy, plan, or insurance" before the period at the end of the second sentence; and

(3) by adding at the end the following new sentence: "The Secretary may waive the provisions of this subsection in the case of an individual claim if he determines that the probability of recovery or amount involved in such claim does not warrant the pursuing of the claim.".

PAYMENT FOR PHYSICIANS' SERVICES WHERE BENEFICIARY HAS DIED

SEC. 954. (a) Section 1870(f) of the Social Security Act is amended to read as follows: 42 USC 1395gg.

"(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and no assignment of the right to payment for such services was made by such individual before his death, and payment for such services has not been made— 42 USC 1395k.

"(1) if the person or persons who furnished the services agree that the reasonable charge is the full charge for the services, payment for such services shall be made to such person or persons, and

"(2) if the person or persons who furnished the services do not agree that the reasonable charge is the full charge for the services, payment for such services shall be made on the basis of an itemized bill to the person who has agreed to assume the legal obligation to make payment for such services and files a request for payment (with such accompanying evidence of such legal obligation as may be required in regulations),

but only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.".

(b) The amendment made by this section shall apply only to claims filed on or after January 1, 1981. 42 USC 1395gg note.

PROVIDER REIMBURSEMENT REVIEW BOARD

SEC. 955. Section 1878(f)(1) of the Social Security Act is amended by inserting the following after the second sentence thereof: "Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which such determination is rendered. If a provider of 42 USC 1395oo.

services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing.".

PAYMENT WHERE BENEFICIARY NOT AT FAULT

42 USC 1395pp.

SEC. 956. (a) Section 1879 of the Social Security Act is amended by adding the following new subsection at the end thereof:

"(e) Where payment for inpatient hospital services or extended care services may not be made under part A of this title on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of section 1861 (e) or (j) by such a provider of services acting in good faith in accordance with the advice of a utilization review committee, professional standards review organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary shall take such action with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertent, or erroneous action.".

Effective date. 42 USC 1395pp note.

(b) The amendment made by subsection (a) shall take effect on January 1, 1981.

TECHNICAL RENAL DISEASE AMENDMENTS

42 USC 1395rr.

SEC. 957. (a) Section 1881(e) of the Social Security Act is amended—

(1) by striking out "and" the first place it appears in paragraph (1) and inserting a comma in lieu thereof;

(2) by inserting "and nonprofit entities which the Secretary finds can furnish equipment economically and efficiently," after "renal dialysis facilities," in paragraph (1);

(3) by striking out "such providers and facilities" and inserting in lieu thereof "such providers, facilities, and nonprofit entities"; and

(4) by striking out "or facility will—" in paragraph (2) and inserting in lieu thereof ", facility, or other entity will—".

42 USC 1395rr.

(b) Section 1881(g) of such Act is amended by striking out "April" each place it appears and inserting in lieu thereof "July".

STUDIES AND DEMONSTRATION PROJECTS

42 USC 1395ll note.

SEC. 958. (a) The Secretary of Health and Human Services shall develop and carry out a demonstration project to determine (1) the extent to which the commencement of nutritional therapy in early renal failure, utilizing (but not limited to) controlled protein substances, can retard or arrest the progression of the disease with a resultant substantive deferment of dialysis, and (2) the administra-

tive, financial, and other aspects of making such nutritional therapy generally available as part of the benefits received under title XVIII of the Social Security Act.

42 USC 1395.

(b) The Secretary shall submit, to the Congress, within one year after the date of the enactment of this Act, a report on the demonstration projects being conducted by the Secretary with respect to waiving the applicable cost sharing amounts which beneficiaries under title XVIII of the Social Security Act have to pay for obtaining a second opinion on having surgery performed. Such report shall include any recommendations for legislative changes in such title which the Secretary finds desirable as a result of such demonstration projects.

Report to Congress.

(c) The Secretary shall conduct a study of the circumstances and conditions under which services furnished by registered dietitians should be covered as a home health benefit under title XVIII of the Social Security Act.

(d) The Secretary shall develop and carry out demonstration projects to determine the administrative, financial, and other aspects of making the services of clinical social workers more generally available as part of the benefits received under title XVIII of the Social Security Act.

(e) The Secretary shall, in consultation with appropriate professional organizations, conduct a comprehensive study of methods for providing coverage under part B of title XVIII of the Social Security Act for orthopedic shoes for individuals with disabling or deforming conditions who require special fitting considerations to help protect against increasing disability or serious medical complications or who require special shoes in conjunction with the use of an orthosis or foot support. The Secretary shall submit to the Congress, no later than July 1, 1981, a report on the findings of this study and such specific legislative recommendations as is appropriate with respect to the utilization, cost control, quality of care, and equitable and efficient administration of such an extension of coverage.

42 USC 1395j.

Report to Congress.

(f) The Secretary shall conduct a study of the circumstances and conditions under which services furnished with respect to respiratory therapy should be covered as a home health benefit under title XVIII of the Social Security Act.

(g) The Secretary shall conduct a study involving a comprehensive analysis of the cost effects of alternative approaches to improving coverage under title XVIII of the Social Security Act for the treatment of various types of foot conditions.

(h) The Secretary shall submit a report on each of the demonstration projects and studies described in subsections (a), (c), (d), (f), and (g). Each such report shall be submitted within twenty-four months of the date of the enactment of this Act and shall contain any recommendations for legislative changes which the Secretary finds desirable as a result of conducting the demonstration project or study with respect to which the report is submitted.

Report.

(i) Where any study or demonstration project conducted under this section relates to payments with respect to services furnished by independent practitioners, such study or project shall include an evaluation of the effect of such payments on coordination of care, cost, quality, and the organization in the provision of services and the utilization of services.

(j) Grants, payments under contracts, and other expenditures made for studies and demonstration projects under this section shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) and the

42 USC 1395i.

42 USC 1395t.

Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved.

TEMPORARY DELAY IN PERIODIC INTERIM PAYMENTS

42 USC 1395g note.

SEC. 959. Notwithstanding section 1815(a) of the Social Security Act, in the case of a hospital which is paid periodic interim payments under such section, the Secretary of Health and Human Services shall provide that with respect to the last twenty-one days for which such payments would otherwise be made during fiscal year 1981, such payments shall be deferred until fiscal year 1982.

PART C—PROVISIONS RELATING TO MEDICAID

DISPUTED MEDICAID CLAIMS

42 USC 1396b.

SEC. 961. (a) Section 1903(d) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1116(d), and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this title, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination (but not to exceed a period of twelve months with respect to disallowances made prior to October 1, 1981, or six months with respect to disallowances made thereafter) at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.".

42 USC 1316.

42 USC 1396b note.

(b) The amendment made by subsection (a) shall be effective with respect to expenditures for services furnished on or after October 1, 1980.

REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITY SERVICES

42 USC 1396a.

SEC. 962. (a) Section 1902(a)(13)(E) of the Social Security Act is amended to read as follows:

"(E) for payment of the skilled nursing facility and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State) which the State finds, and makes

assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each skilled nursing or intermediate care facility and periodic audits by the State of such reports; and".

(b) The amendment made by subsection (a) shall become effective on October 1, 1980. 42 USC 1396a note.

EXTENSION OF INCREASED FUNDING FOR STATE MEDICAID FRAUD CONTROL UNITS

SEC. 963. Section 1903(a)(6) of the Social Security Act is amended by striking out "an amount equal to" and all that follows through "with respect to costs incurred" and inserting in lieu thereof the following: 42 USC 1396b.

"an amount equal to—

"(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

"(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to costs incurred".

CHANGE IN CALENDAR QUARTER FOR WHICH SATISFACTORY UTILIZATION REVIEW MUST BE SHOWN TO RECEIVE WAIVER OF MEDICAID REDUCTION

SEC. 964. Section 1903(g)(3)(B) of the Social Security Act is amended— 42 USC 1396b.

(1) by striking out "October 1, 1977" and inserting in lieu thereof "January 1, 1978"; and

(2) by striking out "the calendar quarter ending on December 31, 1977" and inserting in lieu thereof "any calendar quarter ending on or before December 31, 1978".

REIMBURSEMENT UNDER MEDICAID FOR SERVICES FURNISHED BY NURSE-MIDWIVES

SEC. 965. (a)(1) Subsection (a) of section 1905 of the Social Security Act is amended— 42 USC 1396d.

(A) by striking out "and" at the end of paragraph (16);

(B) by redesignating paragraph (17) as paragraph (18); and

(C) by inserting after paragraph (16) the following new paragraph:

"(17) services furnished by a nurse-midwife (as defined in subsection (m)) which he is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not he is under the supervision of, or associated with, a physician or other health care provider; and".

(2) Such section is further amended by adding at the end thereof the following new subsection:

"(m) The term 'nurse-midwife' means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified "Nurse-midwife."

by an organization recognized by the Secretary, and performs services in the area of management of the care of mothers and babies (throughout the maternity cycle) which he is legally authorized to perform in the State in which he performs such services.".

42 USC 1396a.

(b) Section 1902(a) of such Act is amended—

(1) by striking out "clauses (1) through (5)" in paragraph (13)(B) and inserting in lieu thereof "paragraphs (1) through (5) and (17)";

(2) by striking out "clauses (1) through (5)" in paragraph (13)(C)(i) and inserting in lieu thereof "paragraphs (1) through (5) and (17)";

(3) by striking out "clauses numbered (1) through (16)" in paragraph (13)(C)(ii) and inserting in lieu thereof "paragraphs numbered (1) through (17)"; and

(4) by striking out "clauses (1) through (5) and (7)" in paragraph (14)(A)(i) and inserting in lieu thereof "paragraphs (1) through (5), (7), and (17)".

42 USC 1396a note.

42 USC 1396.

(c)(1) The amendments made by this section shall (except as provided under paragraph (2)) be effective with respect to payments under title XIX of the Social Security Act for calendar quarters beginning more than one hundred and twenty days after the date of the enactment of this Act.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

DEMONSTRATION PROJECTS RELATING TO THE TRAINING OF AFDC RECIPIENTS AS HOME HEALTH AIDES

42 USC 632a.

SEC. 966. (a) The Secretary of Health and Human Services shall enter into agreements with States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of eligible participants as homemakers or home health aides, who shall provide authorized services to elderly or disabled individuals, or other individuals in need of such services, to whom such services, are not otherwise reasonably and actually available or provided, and who would, without the availability of such services, be reasonably anticipated to require institutional care.

"Eligible participant."

(b) For purposes of this section, the term "eligible participant" means an individual who has voluntarily applied for participation and who, at the time such individual enters the project established under this section, has been certified by the appropriate agency of State or local government as being eligible for financial assistance under a State plan approved under part A of title IV of the Social Security Act and as having continuously received such financial assistance during the ninety-day period which immediately precedes the date on which such individual enters such project and who, within such ninety-day period, had not been employed as a homemaker or home health aide.

(c)(1) The Secretary shall enter into agreements under this section with no more than twelve States. Priority shall be given to States

which have demonstrated interest in providing services of the type authorized under this section.

(2) A State may apply to enter into an agreement under this section in such manner and at such time as the Secretary may prescribe.

(3) Any State entering into an agreement with the Secretary under this section must—

(A) provide that the demonstration project shall be administered by a State health services agency designated for this purpose by the Governor (which may be the State agency administering or responsible for the administration of the State plan for medical assistance under title XIX of the Social Security Act); 42 USC 1396.

(B) provide that the agency designated pursuant to subparagraph (A) shall, to the maximum extent feasible, arrange for coordinating its activities under the agreement with activities of other State agencies having related responsibilities;

(C) establish a formal training program, which meets such standards as the Secretary may establish to assure the adequacy of such program, to prepare eligible participants to provide part-time and intermittent homemaker services or home health aide services to individuals who are elderly, disabled, or otherwise in need of such services;

(D) provide for the full-time employment of those eligible participants who successfully complete the training program with one or more public agencies (or, by contract, with private bona fide nonprofit agencies) as homemakers or home health aides, rendering authorized services, under the supervision of persons determined by the State to be qualified to supervise the performance of such services, to individuals described in subsection (a) at wage levels comparable to the prevailing wage levels in the area for similar work;

(E) provide that such services provided under subparagraph (D) shall be made available without regard to income of the individual requiring such services, but that a reasonable fee will be charged (on a sliding scale basis) for such services provided to individuals who have income in excess of 200 percent of the needs standard in such State under the State plan approved under part A of title IV of the Social Security Act for a household of the same size as such individual's household; 42 USC 601.

(F) provide for a system of continuing independent professional review by an appropriate panel, which is not affiliated with the entity providing the services involved, to assure that services are provided only to individuals reasonably determined to be in need of such supportive services;

(G) provide for evaluation of the project and review of all agencies providing services under the project;

(H) submit periodic reports to the Secretary as he may require; and

(I) meet such other requirements as the Secretary may establish for the proper and efficient implementation of the project.

(4) The number of participants in any project shall not exceed that number which the Secretary determines to be reasonable, based upon the capability of the agencies involved to train, employ, and properly utilize eligible participants. Such number may be appropriately modified, subsequently, with the approval of the Secretary.

(5) Any contract with a private bona fide nonprofit agency entered into pursuant to paragraph (3)(D) shall provide for reasonable reimbursement of such agencies for services on a basis proportionate to

the amount of time allocated to individuals eligible to receive such services under this section (and, in case such agency is an institution, the amount of the reimbursement shall not exceed the amount of reimbursement which would have been payable if the services involved had been provided by a free-standing agency).

(6) For purposes of this section, a facility of the Veterans' Administration shall, at the request of the Administrator of Veterans' Affairs, be considered to be a public agency. In the case of any such facility which is so considered to be a public agency, of the costs determined under this section which are attributable to such facility, 90 percent shall be paid by the State and 10 percent by the Veterans' Administration.

(d)(1) For purposes of this section, authorized homemaker and home health aide services include part-time or intermittent—

(A) personal care, such as bathing, grooming, and toilet care;
(B) assisting patients having limited mobility;
(C) feeding and diet assistance;
(D) home management, housekeeping, and shopping;
(E) health-oriented recordkeeping;
(F) family planning services; and
(G) simple procedures for identifying potential health problems.

(2) Such authorized services do not include any services performed in an institution, or any services provided under circumstances where institutionalization would be substantially more efficient as a means of providing such services.

(e)(1) Agreements shall be entered into under this section between the Secretary and the State agency designated by the Governor. Under such agreement the Secretary shall pay to the State, as an additional payment under section 1903 of the Social Security Act for each quarter, an amount equal to 90 percent of the reasonable costs incurred (less the Federal share of any related fees collected) by such State during such quarter in carrying out a demonstration project under this section, including reasonable wages and other employment costs of eligible participants employed full time under such project (and, for purposes of determining the amount of such additional payment, the 10 percent referred to in subsection (c)(6), paid by the Veterans' Administration, shall be deemed to be a cost incurred by the State in carrying out such a project).

42 USC 1396b.

(2) Demonstration projects under this section shall be of a maximum duration of four years, plus an additional time period of up to six months for planning and development, and up to six months for final evaluation and reporting. Federal funding under this subsection shall not be available for the employment of any eligible participant under the project after such participant has been employed for a period of three years.

(f) For purposes of title IV of the Social Security Act, any eligible participant taking part in a training program under a project authorized under this section shall be deemed to be participating in a work incentive program established by part C of such title.

42 USC 601.

42 USC 630.

(g) For the first year (and such additional immediately succeeding period as the State may specify) during which an eligible participant is employed under the project established under this section, such participant shall, notwithstanding any other provision of law, retain any eligibility for medical assistance under a State plan approved under title XIX of the Social Security Act, and any eligibility for social and supportive services provided under the State plan approved under part A of title IV of such Act, which such participant

42 USC 1396.

42 USC 601.

had at the time such participant entered the training program established under this section.

(h) The Secretary shall submit annual reports to the Congress evaluating the demonstration projects carried out under this section, and shall submit a final report to the Congress not more than six months after he has received the final reports from all States participating in such projects.

(i) The Secretary shall, and is hereby authorized to, waive such requirements, including formal solicitation and approval requirements, as will further expeditious and effective implementation of this section.

TITLE X—OTHER SOCIAL SECURITY ACT PROGRAMS; UNEMPLOYMENT COMPENSATION

Subtitle A—Public Assistance

FEDERAL DAY CARE REGULATIONS

SEC. 1001. (a) Section 2002(a)(9) of the Social Security Act is amended by adding at the end thereof the following new subparagraph: 42 USC 1397a.

"(D) The requirements imposed by this paragraph or by any regulations promulgated by the Department of Health and Human Services to carry out this paragraph shall be inapplicable to child day care services provided after June 30, 1980, and prior to July 1, 1981, which meet applicable standards of State and local law.".

(b) The provisions of section 3(f) of Public Law 93-647 shall not apply with respect to child day care services provided after June 30, 1980, and prior to July 1, 1981, which meet applicable standards of State and local law. 42 USC 1397a note.

(c) The Department of Health and Human Services shall assist each State in conducting a systematic assessment of current practices in day care programs funded under title XX of the Social Security Act. Upon completion of such assessments, but not later than June 1, 1981, the Secretary shall provide a summary report of the results of such assessments to the Congress. 42 USC 1397.

ADDITIONAL SAVINGS

SEC. 1002. For provisions of law which reduce spending for fiscal year 1981 under public assistance programs under the Social Security Act in satisfaction of reconciliation requirements imposed by sections 3(a)(8) and 3(a)(15) of H. Con. Res. 307 (96th Congress), see the Social Security Disability Amendments of 1980 (Public Law 96-265) and the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272). *Ante*, p. 441. *Ante*, p. 500.

Subtitle B—Old-Age, Survivors, and Disability Insurance Program

LIMIT ON RETROACTIVE BENEFITS

SEC. 1011. (a) The first sentence of section 202(j)(1) of the Social Security Act is amended by striking out "prior to the end of the 42 USC 402.

twelfth month immediately succeeding such month." and inserting in lieu thereof the following: "prior to—

"(A) the end of the twelfth month immediately succeeding such month in any case where the individual (i) is filing application for a benefit under subsection (e) or (f), and satisfies paragraph (1)(B) of such subsection by reason of clause (ii) thereof, or (ii) is filing application for a benefit under subsection (b), (c), or (d) on the basis of the wages and self-employment income of a person entitled to disability insurance benefits, or

"(B) the end of the sixth month immediately succeeding such month in any case where subparagraph (A) does not apply.".

42 USC 402 note.

(b) The amendment made by subsection (a) shall be effective with respect to applications filed on or after the first day of the first month which begins 60 days or more after the date of the enactment of this Act.

ADDITIONAL SAVINGS

SEC. 1012. For provisions of law which reduce spending for fiscal year 1981 under the old-age, survivors, and disability insurance program in satisfaction of reconciliation requirements imposed by sections 3(a)(8) and 3(a)(15) of H. Con. Res. 307 (96th Congress), see section 5 of Public Law 96-473, and the Social Security Disability Amendments of 1980 (Public Law 96-265).

Ante, p. 2264.
Ante, p. 441.

Subtitle C—Unemployment Compensation Provisions

TERMINATION OF PROVISIONS PROVIDING REIMBURSEMENT FOR UNEMPLOYMENT BENEFITS PAID ON THE BASIS OF PUBLIC SERVICE EMPLOYMENT

SEC. 1021. Part B of title II of the Emergency Jobs and Unemployment Assistance Act of 1974 is amended by adding at the end thereof the following new section:

"TERMINATION

"Public service wages."
26 USC 3304 note.

"SEC. 224. Notwithstanding any other provision of this part, the term 'public service wages' shall not include remuneration for services performed in weeks which begin after the date of the enactment of this section."

WAITING PERIOD FOR BENEFITS

26 USC 3304 note.

SEC. 1022. (a) Section 204(a)(2) of the Federal-State Extended Unemployment Compensation Act of 1970 is amended—

(1) by inserting "(A)" after "compensation", and

(2) by inserting immediately before the period the following: ", or (B) paid for the first week in an individual's eligibility period for which extended compensation or sharable regular compensation is paid, if the State law of such State provides for payment (at any time or under any circumstances) of regular compensation to an individual for his first week of otherwise compensable unemployment".

26 USC 3304 note.

(b)(1) Except as provided in paragraph (2), the amendments made by this section shall apply in the case of compensation paid to individuals during eligibility periods beginning on or after the date of the enactment of this Act.

(2) In the case of a State with respect to which the Secretary of Labor has determined that State legislation is required in order to eliminate its current policy of paying regular compensation to an individual for his first week of otherwise compensable unemployment, the amendments made by this section shall apply in the case of compensation paid to individuals during eligibility periods beginning after the end of the first regularly scheduled session of the State legislature ending more than thirty days after the date of the enactment of this Act.

BENEFITS ON ACCOUNT OF FEDERAL SERVICE TO BE PAID BY EMPLOYING FEDERAL AGENCY

SEC. 1023. (a) Title IX of the Social Security Act is amended by adding at the end thereof the following new section:

"FEDERAL EMPLOYEES COMPENSATION ACCOUNT

"SEC. 909. There is hereby established in the Unemployment Trust Fund a Federal Employees Compensation Account which shall be used for the purposes specified in section 8509 of title 5, United States Code. For the purposes provided for in section 904(e), such account shall be maintained as a separate book account.". 42 USC 1109.

(b) Subchapter I of chapter 85, title 5, United States Code, is amended by adding at the end thereof the following new section:

"§ 8509. Federal Employees Compensation Account 5 USC 8509.

"(a) The Federal Employees Compensation Account (as established by section 909 of the Social Security Act, and hereafter in this section referred to as the 'Account') in the Unemployment Trust Fund (as established by section 904 of such Act) shall consist of— *Supra.*

"(1) funds appropriated to or transferred thereto, and

"(2) amounts deposited therein pursuant to subsection (c).

"(b) Moneys in the Account shall be available only for the purpose of making payments to States pursuant to agreements entered into under this subchapter and making payments of compensation under this subchapter in States which do not have in effect such an agreement.

"(c)(1) Each employing agency shall deposit into the Account amounts equal to the expenditures incurred under this subchapter on account of Federal service performed by employees and former employees of that agency.

"(2) Deposits required by paragraph (1) shall be made during each calendar quarter and the amount of the deposit to be made by any employing agency during any quarter shall be based on a determination by the Secretary of Labor as to the amounts of payments, made prior to such quarter from the Account based on Federal service performed by employees of such agency after December 31, 1980, with respect to which deposit has not previously been made. The amount to be deposited by any employing agency during any calendar quarter shall be adjusted to take account of any overpayment or underpayment of deposit during any previous quarter for which adjustment has not already been made.

"(d) The Secretary of Labor shall certify to the Secretary of the Treasury the amount of the deposit which each employing agency is required to make to the Account during any calendar quarter, and the Secretary of the Treasury shall notify the Secretary of Labor as to

the date and amount of any deposit made to such Account by any such agency.

"(e) Prior to the beginning of each fiscal year (commencing with the fiscal year which begins October 1, 1981) the Secretary of Labor shall estimate—

"(1) the amount of expenditures which will be made from the Account during such year, and

"(2) the amount of funds which will be available during such year for the making of such expenditures,

and if, on the basis of such estimate, he determines that the amount described in paragraph (2) is in excess of the amount necessary—

"(3) to meet the expenditures described in paragraph (1), and

"(4) to provide a reasonable contingency fund so as to assure that there will, during all times in such year, be sufficient sums available in the Account to meet the expenditures described in paragraph (1),

he shall certify the amount of such excess to the Secretary of the Treasury and the Secretary of the Treasury shall transfer, from the Account to the general fund of the Treasury, an amount equal to such excess.

"(f) The Secretary of Labor is authorized to establish such rules and regulations as may be necessary or appropriate to carry out the provisions of this section.

"(g) Any funds appropriated after the establishment of the Account, for the making of payments for which expenditures are authorized to be made from moneys in the Account, shall be made to the Account; and there are hereby authorized to be appropriated to the Account, from time to time, such sums as may be necessary to assure that there will, at all times, be sufficient sums available in the Account to meet the expenditures authorized to be made from moneys therein.".

5 USC 8509 note.

(c) All funds appropriated which are available for the making of payments to States after December 31, 1980, pursuant to agreements entered into under subchapter I of chapter 85 of title 5, United States Code, or for the making of payments after such date of compensation under such subchapter in States which do not have in effect such an agreement, shall be transferred on January 1, 1981, to the Federal Employees Compensation Account established by section 909 of the Social Security Act. On and after such date, all payments described in the preceding sentence shall be made from such Account as provided by section 8509 of title 5, United States Code.

5 USC 8501.

Ante, p. 2657.

LIMITATION ON EXTENDED UNEMPLOYMENT COMPENSATION PROGRAM

26 USC 3304 note.

SEC. 1024. (a) Section 202(a) of the Federal-State Extended Unemployment Compensation Act of 1970 is amended by adding at the end thereof the following new paragraphs:

"(3)(A) Notwithstanding the provisions of paragraph (2), payment of extended compensation under this Act shall not be made to any individual for any week of unemployment in his eligibility period—

"(i) during which he fails to accept any offer of suitable work (as defined in subparagraph (c)) or fails to apply for any suitable work to which he was referred by the State agency; or

"(ii) during which he fails to actively engage in seeking work.

"(B) If any individual is ineligible for extended compensation for any week by reason of a failure described in clause (i) or (ii) of subparagraph (A), the individual shall be ineligible to receive

extended compensation for any week which begins during a period which—

"(i) begins with the week following the week in which such failure occurs, and

"(ii) does not end until such individual has been employed during at least 4 weeks which begin after such failure and the total of the remuneration earned by the individual for being so employed is not less than the product of 4 multiplied by the individual's average weekly benefit amount (as determined for purposes of subsection (b)(1)(c)) for his benefit year.

"(C) For purposes of this paragraph, the term 'suitable work' means, with respect to any individual, any work which is within such individual's capabilities; except that, if the individual furnishes evidence satisfactory to the State agency that such individual's prospects for obtaining work in his customary occupation within a reasonably short period are good, the determination of whether any work is suitable work with respect to such individual shall be made in accordance with the applicable State law. "Suitable work."

"(D) Extended compensation shall not be denied under clause (i) of subparagraph (A) to any individual for any week by reason of a failure to accept an offer of, or apply for, suitable work—

"(i) if the gross average weekly remuneration payable to such individual for the position does not exceed the sum of—

"(I) the individual's average weekly benefit amount (as determined for purposes of subsection (b)(1)(C)) for his benefit year, plus

"(II) the amount (if any) of supplemental unemployment compensation benefits (as defined in section 501(c)(17)(D) of the Internal Revenue Code of 1954) payable to such individual for such week; 26 USC 501.

"(ii) if the position was not offered to such individual in writing and was not listed with the State employment service;

"(iii) if such failure would not result in a denial of compensation under the provisions of the applicable State law to the extent that such provisions are not inconsistent with the provisions of subparagraphs (C) and (E); or

"(iv) if the position pays wages less than the higher of—

"(I) the minimum wage provided by section 6(a)(1) of the Fair Labor Standards Act of 1938, without regard to any exemption; or 29 USC 206.

"(II) any applicable State or local minimum wage.

"(E) For purposes of this paragraph, an individual shall be treated as actively engaged in seeking work during any week if—

"(i) the individual has engaged in a systematic and sustained effort to obtain work during such week, and

"(ii) the individual provides tangible evidence to the State agency that he has engaged in such an effort during such week.

"(F) For purposes of section 3304(a)(11) of the Internal Revenue Code of 1954, a State law shall provide for referring applicants for benefits under this Act to any suitable work to which clauses (i), (ii), (iii), and (iv) of subparagraph (D) would not apply. 26 USC 3304.

"(4) No provision of State law which terminates a disqualification for voluntarily leaving employment, being discharged for misconduct, or refusing suitable employment shall apply for purposes of determining eligiblity for extended compensation unless such termination is based upon employment subsequent to the date of such disqualification.

"(5) No payment shall be made under this Act to any State in respect of any sharable regular compensation paid to any individual for any week if, under the rules of paragraphs (3) and (4), extended compensation would not have been payable to such individual for such week.".

26 USC 3304 note.

(b) The amendment made by this section shall apply with respect to weeks of unemployment beginning after March 31, 1981.

CERTIFICATION OF STATE UNEMPLOYMENT LAWS

26 USC 3304 note.

SEC. 1025. On October 31 of any taxable year after 1980, the Secretary of Labor shall not certify any State, as provided in section 3304(c) of the Internal Revenue Code of 1954, which, after reasonable notice and opportunity for a hearing to the State agency, the Secretary of Labor finds has failed to amend its law so that it contains each of the provisions required by reason of the enactment of the preceding provisions of this subtitle to be included therein, or has with respect to the 12-month period ending on such October 31, failed to comply substantially with any such provision.

26 USC 3304.

ADDITIONAL SAVINGS

SEC. 1026. For provisions of law which reduce spending for fiscal year 1981 under the unemployment compensation program in satisfaction of reconciliation requirements imposed by sections 3(a)(8) and 3(a)(15) of H. Con. Res. 307 (96th Congress), see sections 415 and 416 of the Multiemployer Pension Plan Amendments Act of 1980 (Public Law 96-364).

Ante, p. 1310.

TITLE XI—REVENUE MEASURES

Revenue Adjustments Act of 1980.

26 USC 1 note.

SEC. 1100. SHORT TITLE.

This title may be cited as the "Revenue Adjustments Act of 1980".

Subtitle A—Housing Bonds

Mortgage Subsidy Bond Tax Act of 1980.

26 USC 1 note.

SEC. 1101. SHORT TITLE.

This subtitle may be cited as the "Mortgage Subsidy Bond Tax Act of 1980".

SEC. 1102. MORTGAGE SUBSIDY BONDS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1954 (relating to items specifically excluded from gross income) is amended by inserting after section 103 the following new section:

26 USC 103A.

"SEC. 103A. MORTGAGE SUBSIDY BONDS.

"(a) GENERAL RULE.—Except as otherwise provided in this section, any mortgage subsidy bond shall be treated as an obligation not described in subsection (a) (1) or (2) of section 103.

26 USC 103.

"(b) MORTGAGE SUBSIDY BOND DEFINED.—

"(1) IN GENERAL.—For purposes of this title, the term 'mortgage subsidy bond' means any obligation which is issued as part of an issue a significant portion of the proceeds of which are to be used directly or indirectly for mortgages on owner-occupied residences.

BEST DOCUMENT AVAILABLE

"For the holder of the economic interest in the case of a production payment, see section 636."

(2) TECHNICAL AND CONFORMING AMENDMENTS.—The table of sections for subpart B of chapter 65 of such code is amended by adding at the end thereof the following new item:

"Sec. 6429. Credit and refund of chapter 45 taxes paid by royalty owners."

(d) DENIAL OF DEDUCTION.—

(1) IN GENERAL.—Part IX of subchapter B of chapter 1 of such Code (relating to items not deductible) is amended by adding at the end thereof the following new section:

"SEC. 280D. PORTION OF CHAPTER 45 TAXES FOR WHICH CREDIT OR REFUND IS ALLOWABLE UNDER SECTION 6429. 26 USC 280D.

"No deduction shall be allowed for that portion of the tax imposed by section 4986 for which a credit or refund is allowable under section 6429." 26 USC 4986. 26 USC 6429.

(2) CONFORMING AMENDMENT.—The table of sections for part IX of subchapter B of chapter 1 of such Code is amended by adding at the end thereof the following new item:

"Sec. 280D. Portion of chapter 45 taxes for which credit or refund is allowable under section 6429."

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years ending after February 29, 1980. 26 USC 280D

Subtitle E—Inclusion in Wages for Purposes of Social Security and Unemployment Taxes of Employer

SEC. 1141. INCLUSION IN WAGES OF EMPLOYEE TAXES PAID BY EMPLOYER.

(a) SOCIAL SECURITY TAX.—

(1) AMENDMENT OF INTERNAL REVENUE CODE OF 1954.—Paragraph (6) of section 3121(a) of the Internal Revenue Code of 1954 (defining wages) is amended to read as follows: 26 USC 3121.

"(6) the payment by an employer (without deduction from the remuneration of the employee)—

"(A) of the tax imposed upon an employee under section 3101, or 26 USC 3101.

"(B) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;".

(2) AMENDMENT OF SOCIAL SECURITY ACT.—Subsection (f) of section 209 of the Social Security Act is amended to read as follows: 42 USC 409.

"(f) The payment by an employer (without deduction from the remuneration of the employee)—

"(1) of the tax imposed upon an employee under section 3101 of the Internal Revenue Code of 1954, or 26 USC 3101.

"(2) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;".

26 USC 3306.

(b) FEDERAL UNEMPLOYMENT TAX.—Paragraph (6) of section 3306(b) of the Internal Revenue Code of 1954 (defining wages) is amended to read as follows:

"(6) the payment by an employer (without deduction from the remuneration of the employee)—

"(A) of the tax imposed upon an employee under section 3101, or

26 USC 3101.

"(B) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;".

26 USC 3121 note.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply with respect to remuneration paid after December 31, 1980.

(2) EXCEPTION FOR STATE AND LOCAL GOVERNMENTS.—

(A) The amendments made by this section (insofar as they affect the application of section 218 of the Social Security Act) shall not apply to any payment made before January 1, 1984, by any governmental unit for positions of a kind for which all or a substantial portion of the social security employee taxes were paid by such governmental unit (without deduction from the remuneration of the employee) under the practices of such governmental unit in effect on October 1, 1980.

42 USC 418.

"Social security employee taxes."

(B) For purposes of subparagraph (A), the term "social security employee taxes" means the amount required to be paid under section 218 of the Social Security Act as the equivalent of the taxes imposed by section 3101 of the Internal Revenue Code of 1954.

42 USC 418.

26 USC 3101.

"Governmental unit."

(C) For purposes of subparagraph (A), the term "Governmental unit" means a State or political subdivision thereof within the meaning of section 218 of the Social Security Act.

26 USC 418.

Subtitle F—Telephone Tax

SEC. 1151. TELEPHONE TAX CONTINUED AT 2 PERCENT FOR 1981.

26 USC 4251.

(a) IN GENERAL.—The table contained in paragraph (2) of section 4251(a) of the Internal Revenue Code of 1954 (relating to imposition of tax on communication services) is amended by striking out the last 2 lines of such table and inserting in lieu thereof the following:

"During 1980 or 1981	2
During 1982	1".

(b) CONFORMING AMENDMENT.—Subsection (b) of section 4251 of such Code is amended by striking out "January 1, 1982" and inserting in lieu thereof "January 1, 1983".

Subtitle G—Increase Until 1993 in the Duties on Certain Imports of Ethyl Alcohol

SEC. 1161. INCREASE UNTIL 1993 IN THE DUTIES ON ETHYL ALCOHOL IMPORTED FOR FUEL USE.

(a) AMENDMENTS TO APPENDIX TO TSUS.—

(1) FOR 1981.—Effective with respect to articles entered on or after January 1, 1981, subpart A of part 1 of the Appendix to the Tariff Schedules of the United States (19 U.S.C. 1202) is amended by inserting in numerical sequence the following new item:

"	901.50	Ethyl alcohol (provided for in item 427.88, part 2D, schedule 4) when imported to be used in producing a mixture of gasoline and alcohol or a mixture of a special fuel and alcohol for use as fuel, or when imported to be used otherwise as fuel	10¢ per gal.	10¢ per gal.	On or before 12/31/81	".

(2) FOR 1982.—Effective with respect to articles entered on or after January 1, 1982, item 901.50 of the Tariff Schedules of the United States (as added by paragraph (1)) is amended by striking out "10" in columns numbered 1 and 2 and inserting in lieu thereof "20"; and by striking out "12/31/81" and inserting in lieu thereof "12/31/82".

(3) AFTER 1982 AND UNTIL 1993.—Effective with respect to articles entered on or after January 1, 1983, such item 901.50 is amended by striking out "20" in columns numbered 1 and 2 and inserting in lieu thereof "40", and by striking out "12/31/82" and inserting in lieu thereof "12/31/92".

(b) DEFINITION.—For purposes of subsection (a), the term "entered" means entered, or withdrawn from warehouse, for consumption in the customs territory of the United States.

Approved December 5, 1980.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 96-1167 (Comm. on the Budget) and No. 96-1479 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 126 (1980):

June 30, S. 2885 considered and passed Senate.

July 23, S. 2939 considered and passed Senate.

Sept. 4, H.R. 7765 considered and passed House.

Sept. 17, passages of S. 2885 and S. 2939 vacated in Senate; H.R. 7765, amended, passed in lieu.

Sept. 18, House disagreed to Senate amendment and agreed to a conference.

Dec. 3, House and Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 16, No. 49:

Dec. 5, Presidential remarks.

BEST DOCUMENT AVAILABLE

96th Congress
2d Session } HOUSE OF REPRESENTATIVES { REPORT
No. 96-1167

OMNIBUS RECONCILIATION ACT OF 1980

REPORT

OF THE

COMMITTEE ON THE BUDGET

HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 7765

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SECTION 3 OF THE FIRST CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 1981

together with

SUPPLEMENTAL, ADDITIONAL, AND MINORITY VIEWS

JULY 21, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1980

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96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 96-1167

OMNIBUS RECONCILIATION ACT OF 1980

JULY 21, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. GIAIMO, from the Committee on the Budget, submitted the following

REPORT

[To accompany H.R. 7765]

[Including cost estimates of the Congressional Budget Office]

The Committee on the Budget, to whom was submitted reconciliation recommendations pursuant to section 3 of the First Concurrent Resolution on the Budget for Fiscal Year 1981, having considered the same, reports favorably thereon and recommends that the bill embodying those recommendations do pass.

STATEMENT OF THE COMMITTEE ON THE BUDGET

The Committee on the Budget is pleased to report that House committees have acted promptly and responsibly to comply with the reconciliation directives of the Congress contained in the First Budget Resolution for Fiscal Year 1981. In the following sections of this report, each House committee involved has provided Report language to accompany its recommendations. Congressional Budget Office cost estimates are also included. Consistent with the provisions of the Budget Act, the Budget Committee has made no substantive changes in the recommendations or the Report language submitted by the committees involved.

When Congress approved the budget targets for fiscal year 1981, it agreed that growth in Federal spending should be restrained. If deficits accompanied by high rates of inflation are ultimately to be eliminated, the Federal Government must initiate basic reforms in its spending policies. Congress accepted this responsibility in approving reconciliation as well as restraint in discretionary spending in the First Budget Resolution for Fiscal Year 1981.

III. Changes in the Medicaid and Medicare Programs

(NOTE.—A substantial number of the recommendations of the Committee on Interstate and Foreign Commerce concerning provisions affecting the Medicare and Medicaid programs are identical to provisions recommended by the Committee on Ways and Means. In the Reconciliation bill, only one set of the identical provisions is included; these amendments are found in the bill in Title VIII, the Ways and Means section, numbered Sections 842 through 868. In determining the provision of the bill which is referenced in the descriptive language appearing below, 540 should be added to each section number appearing in the Commerce discussion (i.e., Section 302 of the Commerce version refers to Section 842 of the bill; Section 310 of the Commerce version refers to Section 850 of the bill, and so on). Beginning with Section 331 of the Commerce recommendations, relating solely to the Medicaid program, the section references will be correct, and will parallel the section number contained in the bill.)

A. General Discussion of the Committee Recommendations

SHORT TITLE (SECTION 301)

This section provides that these amendments may be cited as the "Medicare and Medicaid Amendments of 1980."

EXPANDED MEMBERSHIP OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (SECTION 302)

The section authorizes each professional standards review organization (PSRO) to offer membership, at its own option, to nonphysician health professionals who hold independent hospital admitting privileges.

Under present law, membership in a professional standards review organization is limited to licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in the organization's area. However, the provision of health care services furnished in a hospital setting may involve orders by independent health professionals other than physicians; for example, dentists and podiatrists. Since such health professionals hold hospital admitting privileges in many jurisdictions and order services for which payment may be made under medicare and medicaid, the Committee believes it would be appropriate to provide the opportunity—consistent with established professional relationships in each community—for such professionals to participate in the evaluation of these services as members of the PSRO. It is expected that such membership, where the invitation is extended by the PSRO, would be made available under the same general conditions now applicable to doctors of medicine or osteopathy. And the same requirements would apply; no independent health professional would review services that he or she delivered, for example. Addditionally the bill retains the requirement of existing law that only doctors of medicine or osteopathy may make final determinations with respect to the services performed by other M.D.'s or D.O.'s.

The Committee believes that inclusion of consumer representatives on the boards of local PSRO's should be left to the option of each organization. Many PSRO's have already, on a voluntary basis, invited consumer representatives to sit on their boards. The Committee believes that such voluntary actions should be encouraged.

REGISTERED NURSE AND DENTIST MEMBERSHIP ON STATEWIDE COUNCIL ADVISORY GROUP (SECTION 303)

The section provides that at least one registered professional nurse and one dentist would have to be included in the membership of the advisory group to each Statewide Professional Standards Review Council.

Under present law, the advisory group to a Statewide Council must be composed of representatives of health care practitioners (other than physicians) and health care institutions. In recognition of the impact the nursing and dental professions have on the delivery and quality of care, the Committee believes it is desirable to require each Statewide Council advisory group to include, in addition to representatives of other appropriate professional disciplines, at least one registered professional nurse and one dentist.

NONPHYSICIAN MEMBERSHIP ON NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL (SECTION 304)

Under the section, the membership of the National Professional Standards Review Council would be expanded to include a dentist, a registered professional nurse, and one other nonphysician health professional.

Under present law, membership on the National Council, which advises the Secretary on policy and administrative matters relating to the PSRO program, is limited to doctors of medicine and osteopathy. The Committee believes, however, that since the National Council is responsible for providing policy and administrative advice on all services covered under medicare and medicaid, including services furnished by nonphysician health professionals, such a limitation on membership detracts from the effective performance of the Council's function. Providing for the membership of representatives of the nursing, dental and other health care professions would enhance the exchange of professional judgments on standards and utilization of services among these disciplines.

The Committee expects that the Secretary, in selecting the member to represent the several nonphysician health disciplines, will develop a selection process that will assure both the equitable rotation of the position among the recognized scientific health care disciplines and the selection of a representative of recognized standing and distinction in his or her chosen scientific field.

EFFICIENCY IN DELEGATED REVIEW (SECTION 305)

The section provides for PSRO's to delegate their review functions to utilization review committees of hospitals, but only when the utilization committee demonstrates its capacity to carry out the required activities effectively, efficiently, and in timely fashion.

Under present law, PSRO's consider only effectiveness and timeliness of review in making delegation decisions. The Committee is concerned that, although hospital utilization review committees may be able to demonstrate effectiveness and timeliness, they may not in all cases be able to undertake these review activities as economically (on a cost per review basis) as the PSRO serving that hospital's area.

Where this is the case, the Committee intends that the PSRO undertake the review activities. Accordingly, the Committee has added "efficiently" to the standards that a hospital utilization review committee must meet in order to continue to conduct delegated reviews.

When the PSRO law was enacted, PSRO's were not responsible for delegated hospital review budgets. Currently, however, PSRO's are limited in how much they can spend on review and PSRO's must negotiate review budgets with delegated hospitals. Although PSRO's have been negotiating lower unit cost rates with hospitals, based on hospital financial reports fiscal intermediaries can reimburse hospitals at higher rates than those negotiated. Delegated hospitals therefore have little incentive to hold their expenditures to the negotiated level. The only option available to PSRO's interested in withdrawing delegation to control costs is to demonstrate that the delegated review had been ineffective.

The Committee supports measures to control PSRO review costs and feels that it is necessary to consider the cost of review in making decisions about delegation. This will enable medicare and medicaid to achieve the most efficient conduct of effective review.

REQUIRED ACTIVITIES OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (SECTION 306)

The section provides that, in order to obtain full designation, a conditionally designated PSRO must, at a minimum, satisfactorily conduct reviews of routine inpatient health care services provided to medicare or medicaid beneficiaries by or in hospitals in its area. The section eliminates the requirement of current law that a PSRO must review long-term care services in order to be fully designated and must, if capable, review ambulatory care services within two years of becoming fully designated. In addition, the section directs the Secretary to establish a program for the evaluation of the cost-effectivenss of review of particular health care services by PSRO's, and to require PSRO's to conduct review of additional health care services (except as part of the evaluation program) only where such review has been found to be cost-effective or yields other significant benefits. Finally, the section authorizes the Secretary to designate another qualified PSRO to conduct reviews of particular services not yet being performed by designated PSRO's.

Under present law each PSRO is required to assume review responsibility for care (including physicians' services) delivered by or in all types of institutions within four years of receiving conditional designation. The law further permits an extension for two additional years of a conditionally designated PSRO's trial period if failure to implement reviews in all types of institutions is due to causes beyond the PSRO's control. Within two years of receiving full designation, however, the Secretary must require those PSRO's with the capability to review ambulatory care services to assume this responsibility.

The Committee generally favors the expansion of PSRO review activities into areas other than routine inpatient hospital services. The Committee recognizes, however, that the expansion contemplated by current law would be premature in the absence of evidence that expanded review would be cost-effective or would offer other signifi-

cant benefits. Accordingly, the section requires the Secretary to establish an evaluation program to determine whether long term, ambulatory and ancillary care reviews are cost-effective. In designing the evaluation program, the Secretary is directed to ensure that a statistically valid method is used to choose which PSRO's will and will not be required to implement the particular types of review being evaluated. Any statistically valid method should have at least the following characteristics:

—The creation of an "experimental" group of PSRO's that implement the new review activity, and a "control" group of PSRO's that do not implement the new activity;

—The selection of the experimental and control groups in such a way as to maximize the similarity between the two groups in the period before the experimental group implements the new activity; and

—The section of the experimental and control groups in a way which permits a comparison that is, in the statistical sense, unbiased.

The Committee recognizes that studying the utilization of health care services is a very complex undertaking and it is often difficult to make definitive determinations regarding cause and effect in this area. The Committee further recognizes that it will be difficult to design a statistically valid study because of the many factors which can affect utilization and quality practices and any resulting changes in these practices. The Committee, however, encourages the Secretary to control for as many extraneous factors as possible in studying PSRO impact in the long term and ambulatory care settings and on ancillary services. The Committee further recognizes that studies reported in the professional literature, or other evaluations, may also be used in determining whether review of particular health services is cost-effective or yields other significant benefits if such studies or evaluations are of comparable reliability to the studies required under the evaluation program.

These new requirements reflect the concern of the Committee that the effectiveness of PSRO review activities must be demonstrated more persuasively than has been possible in the past. Evaluations carried out to date by the Health Care Financing Administration and by the Congressional Budget Office of PSRO review of admissions and lengths of stay in acute-care hospitals suggests that such review may reduce utilization. The CBO has also concluded that the best estimate is that the net savings generated by the PSRO program are about 30 percent less than program costs, whereas the Health Care Financing Administration evaluations have concluded that the program is cost effective. Both the CBO and HCFA estimates, however, rest on controversial assumptions and are open to considerable error. The section is designed to address this problem by mandating that valid evaluations be carried out before PSRO review of new services is generally required.

Based on a study outcome that PSRO review is cost effective or yields other significant benefits, the Secretary could require PSRO's to implement those types of review addressed in the study. Examples of other significant benefits that might be identified, and would justify requiring PSRO implementation of these types of review, would be

demonstrated positive impacts on the quality of patient care, shifts in utilization to appropriate care settings, or reductions in the use of inappropriate treatment or services.

It is the Committee's intention that PSRO's which are now doing additional kinds of review of which on their own initiative request to implement ancillary, long term, or ambulatory care review should be funded. The Committee feels that such funding should be continued and encouraged to enable PSRO's to carry out types of review directed at particular problems in their areas or to reward PSRO's which have demonstrated positive performance in the area of hospital review. However, prior to the completion of the study, the Secretary could not require a PSRO to conduct a type of review it is not currently conducting if the PSRO does not want to initiate that particular type of review (unless it is necessary in order to obtain the data base needed for evaluation). If the evaluation study finds that a particular type of review is cost-effective or yields other significant benefits, the Secretary could then require other PSRO's to conduct it.

In cases where the Secretary has determined that reviews of a particular service are cost-effective or yield other significant benefits but the PSRO for the designated area does not have the capacity to undertake such additional review, the bill authorizes the Secretary to grant another qualified PSRO (in reasonable proximity to the providers and practitioners whose services are to be reviewed) to assume that authority and responsibility until the first PSRO has acquired the capacity to undertake such reviews.

RESPONSE OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS TO FREEDOM OF INFORMATION ACT REQUESTS (SECTION 307)

The section provides that no PSRO will be required to make available any records pursuant to a request under the Freedom of Information Act until 180 days after the entry of a final court order requiring such disclosure.

Under current law, information and data collected and generated by PSRO's in the course of their review activities are, as a general rule, confidential. There are, however, several exceptions that permit disclosure of certain types of information to various persons or agencies for various purposes. For example, PSRO's are required to provide information to Federal and state fraud and abuse agencies to assist them in their investigative work. PSRO's are also required to make information available to state and local health planning agencies to assist them in carrying out health planning and related activities. The Department of Health, Education and Welfare is now in the process of implementing these various statutory requirements by regulation. See 44 *Fed. Reg.* 3058 (Jan. 15, 1979).

Recently a U.S. District Court ruled that some of the data held by PSRO's concerning patterns of practice of individual institutions and individual practitioners participating in Medicare and Medicaid were subject to disclosure under the Freedom of Information Act. *Public Citizen Health Research Group* v. *Department of HEW*, *Group* v. *Department of HEW*, C.A. No. 77-2093 (D.D.C., Sept. 25, 1979). None of the data sought in this litigation would identify individual patients or disclose their medical records. The Court stayed its

order requiring release of the information at issue pending appeal, which has been taken.

This litigation has given rise to great concern among PSRO's and the medical community in general. There is considerable uncertainty as to what PSRO information will be disclosable, to whom, and under what circumstances. A resolution of these complex and competing considerations is clearly needed, so that all interested parties—PSRO's, physicians, program beneficiaries, other consumers, health planning agencies, fraud and abuse agencies, state Medicaid agencies, state licensure boards, state rate-setting agencies, and health and medical researchers—will know how PSRO data is to be treated.

Toward this end, the Committee has recommended a provision to assure that no PSRO could be required to disclose any data or information pursuant to a Freedom of Information Act request until 180 days following the conclusion of the appeal and the entry of a final order in the *Public Citizen* case. This provision is not intended to make moot or otherwise reflect Congressional intent with respect to the decision in the appeal of this case or related cases. The Committee desires the benefit of full judicial consideration of the issues raised by that litigation while at the same time assuring Congress the opportunity to review the propriety of disclosure of whatever data is ultimately ordered released. In addition, the Committee expects that HEW will expedite its development of a disclosure policy under current law, so that the Congress will have the benefit of the Department's final views on these issues as well. Finally, this provision will also give the Congress time to study the recommendations of the National Academy of Sciences, which has agreed to undertake a study of the issues raised by this litigation. This provision is not intended to bar, or in any way restrict, access to PSRO data as provided for under section 1166 of the Social Security Act, section 1513(d) of the Public Health Service Act, or regulations implementing these sections.

CONSULTATION BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS WITH HEALTH CARE PRACTITIONERS (SECTION 308)

In lieu of the present requirement of formal advisory groups of health care practitioners to individual PSRO's, the action would authorize the Secretary to establish more flexible guidelines to assure appropriate operational PSRO consultation with representatives of all health care disciplines on the performance of review activities.

Present law requires that advisory groups to PSRO's must be established and must be composed of not less than seven or more than eleven members who are representatives of health care practitioners other than physicians. Such formal advisory groups, however, have proved to be cumbersome and not totally effective in assuring appropriate consultation on operational matters. The Committee believes that more effective and practical arrangements could be achieved by authorizing the Secretary to establish and apply flexible guidelines relating to organizational relationships—including the range, frequency, and continuity of contacts—for assuring operational PSRO consultation with all health care disciplines.

The Committee notes that its intention in providing more flexible authority to the Secretary is to allow the requirements for consultation

with health care practitioners to be applied in a less burdensome manner than under current law. In specifying the frequency and manner of consultations, the Secretary would be expected to set general standards rather than specific formal requirements and to encourage appropriate consultation without establishing rigid and unreasonable conditions.

REVIEW OF ROUTINE HOSPITAL ADMISSION SERVICES AND PREOPERATIVE HOSPITAL STAYS BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (SECTION 309)

Under the section, PSRO's would be authorized to focus preadmission review on those areas of relatively frequent overutilization—particularly routine hospital admission services and excessive preoperative stays—to assure that medicare and medicaid payments are made only when the routine tests and unusually long preoperative stays for elective conditions are medically appropriate.

Present program policies direct PSRO's to review the appropriateness of hospital services received by medicare and medicaid patients. This review has been limited largely to a review of the need for the patient to be admitted to the hospital and the appropriateness of the length of stay. However, a number of studies have demonstrated that unnecessary or avoidable utilization occurs with respect to certain hospital practices that may not have received sufficient attention by PSRO's, including: diagnostic tests routinely provided on admission without a physician's order; weekend elective admissions to hospitals which are not equipped or staffed to provide needed diagnostic services on weekends; and preoperative stays for elective procedures of more than one day without justification for the additional days. Consequently, the Committee is of the view that PSRO's should have the clear authority to undertake preadmission reviews of these areas of overutilization so that payments are not made for medically unnecessary routine hospital services or preoperative days. As part of this authority it is intended that PSRO's should be able to look carefully at surgical procedures to determine which might be appropriately performed on ambulatory basis in a hospital outpatient department, an ambulatory surgical center or a properly equipped physician's office.

Further, the section provides that the Secretary may direct a PSRO to exercise its authority to do preadmission review where: (a) the Secretary has determined such review is cost effective or yields other significant benefits (as required in section 306), (b) the Secretary finds the PSRO is capable of making such determinations on a timely basis, and (c) the Secretary has determined appropriate procedures will be applied to assure prompt notification of providers, physicians and persons affected. The Committee notes that it would expect the Secretary to negotiate with the PSRO to determine its ability and capacity to carry out such preadmission review, and in most cases the decision to have the PSRO undertake this responsibility would be a joint one.

STUDY OF PSRO NORMS, STANDARDS AND CRITERIA (SECTION 310)

The section requires the Secretary to conduct, in consultation with the National Professional Standards Review Council, a nationwide

study of the differences in PSRO's medical criteria and length-of-stay norms. The Secretary would be required to report the findings of this study to the Congress within one year of enactment.

Present laws requires PSRO's to use professionally developed norms of care based on typical patterns of practice in their areas, and also requires the National Council to exercise oversight and approval over PSRO norms which are significantly different from professionally developed regional norms.

The Committee believes that basing PSRO criteria and norms exclusively on typical practice patterns in the area may serve to perpetuate the status quo, including whatever inappropriate practices may be present in the area. While there are legitimate reasons for some variations in medical criteria and norms from area to area, there is also substantial evidence of widely different criteria and norms for similar patients under similar conditions. For example, the typical length of stay for a gall bladder removal varies by as much as 6 days in different sections of the United States. The intent of the study provided for in the bill is to determine what basis there is for such differences, so that the Congress can ascertain whether some steps should be taken to avoid the perpetuation of inefficiencies.

NONPROFIT HOSPITAL PHILANTHROPY (SECTION 311)

The section provides that, in determining the amount of reimbursement for nonprofit hospitals under the medicare, medicaid, and maternal and child health (Title V) programs, the following items are not to be deducted from operating costs: (a) unrestricted grants, gifts, and income from endowments; (b) donor-designated or restricted grants, gifts, or income from endowment; (c) unrestricted grants or gifts, or income therefrom, designated by the hospital's governing board as unavailable for operating funds; (d) governmental grants that are not available for use as operating funds; (e) sale or mortgage of real estate or other capital assets acquired through gift or grant that are unavailable for use as operating funds (except gains and losses realized from the disposal of depreciable assets); and (f) sinking funds established exclusively to make payments to third parties for financing capital improvements.

Under current law, grants, gifts, and endowment income designated by the donor to pay for specific operating costs are deducted from those costs in determining the reasonable cost of services for purposes of reimbursement under medicare, medicaid, and the maternal and child health programs. The Committee heard testimony that this policy may discourage philanthropic contributions to nonprofit hospitals for specific operating costs. The Committee believes that philanthropic support for health care should be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system. Accordingly, the section provides that grants, gifts, and income from endowments, whether restricted by the donor or not, are not to be deducted from operating costs in determining the level of reimbursement under the federal payment programs.

The Committee notes that although this section does not address the issue, the Committee is concerned that State policies should not in-

appropriately discourage philanthropic support of non-profit hospitals. For this reason, the Committee would encourage States to adopt policies to protect philanthropic giving.

CONSULTATIVE SERVICES FOR SKILLED NURSING FACILITIES (SECTION 312)

Under the section, the provision of present law authorizing medicare reimbursement for consultative services furnished by State agencies to skilled nursing facilities would be repealed.

Under present law, the State agency responsible for determining skilled nursing facility compliance with medicare conditions of participation may furnish specialized consultative services, at the request of the facility, to help it achieve or maintain compliance with the conditions. However, since there have been no requests under this provision for medicare funding of consultative services, it is apparent that the provision is unnecessary. Moreover, the Committee believes that adequate provision has been made under the medicaid program for furnishing consultation to any skilled nursing facilities that might require such services.

STUDY OF NEED FOR DUAL PARTICIPATION OF SKILLED NURSING FACILITIES (SECTION 313)

The section requires the Secretary to conduct a study of the causes for the present scarcity of skilled nursing home beds, including the extent to which existing laws and regulations (as well as other factors) discourage dual participation of skilled nursing facilities in the medicare and medicaid programs, and report the results of the study to Congress within one year after enactment.

Under present law, skilled nursing facilities are not required to participate in both the medicare and medicaid programs. As a result there are a number of areas of the country in which there are fewer beds available, either for medicare or medicaid beneficiaries, than might otherwise be the case if all skilled nursing facilities participated in both programs. While there are many opinions as to why a large number of facilities choose not to participate in both programs, the Committee believes there is little documentation and objective analysis of the reasons for this situation. To eliminate this gap in knowledge, the section would direct the Secretary to conduct a thorough study of the situation and assess the feasibility and potential consequences of requiring dual participation. In conducting the study, the Secretary would be required to consult with professional organizations, private insurers, nursing home providers and consumers of skilled nursing services, and would be required to submit a report on the results of the study together with any recommendations for legislative changes.

ALTERNATIVE TO DECERTIFICATION OF LONG-TERM CARE FACILITIES OUT OF COMPLIANCE WITH CONDITIONS OF PARTICIPATION; LOOK BEHIND AUTHORITY (314)

The section authorizes the Secretary and State Medicaid agencies to deny reimbursement for services furnished by a skilled nursing facility (SNF) or an intermediate care facility (ICF) for all medicare and

medicaid beneficiaries admitted to the facility after the date the Secretary determines that it is substantially out of compliance with the conditions of, or requirements for, participation. In the case of a facility with deficiencies that immediately jeopardize the health and safety of its patients, the bill requires the Secretary and the State agency to decertify the facility, and while decertification is underway, to deny reimbursement for medicare and medicaid patients admitted subsequent to the determination of noncompliance. In addition, the section authorizes the Secretary to "look behind" a State's survey of an SNF or ICF and, where the Secretary finds that a facility does not meet the conditions of, or requirements for, participation, to terminate the participation of the facility in medicare and medicaid.

At present, the only sanction available in many jurisdictions to penalize a skilled nursing facility which is out of compliance with the conditions of participation in the medicare and medical programs is to terminate that facility's participation in the program. Frequently, this sanction involves an overriding hardship to program beneficiaries which makes its use desirable, if not impossible.

In the case of facilities that are substantially out of compliance but do not have deficiencies that immediately jeopardize the health and safety of their patients, the section gives the Secretary authority to impose an intermediate sanction, short of the more drastic step of program termination. The Secretary would be expected to define by regulation the grounds for the imposition of an intermediate sanction. It is the expectation of the Committee that the existence of sanctionable deficiencies with the conditions of participation would generally be determined during the course of the formal State survey of the facility or HEW's compliance validation surveys. The denial of reimbursement for services furnished to medicare or medicaid beneficiaries admitted after a date designated by the Secretary would continue until such time as the deficiencies have been corrected or it is determined that good faith efforts to correct deficiencies are being made. This alternative sanction would be applicable for a limited period, not to exceed 12 months; thereafter, the bill would require the Secretary to decertify the facility.

In the case of facilities that are substantially out of compliance and have deficiencies that immediately jeopardize the health and safety of the patients, the section directs the Secretary or State agency to decertify the facility and, while the decertification process is underway, to deny reimbursement for any services furnished to medicare or medicaid beneficiaries admitted after a designated date. This additional sanction would be applicable for the duration of the decertification or termination proceeding.

Under the provision, a facility would have an opportunity to develop and implement a plan for correcting its deficiencies, in accordance with existing medicare policies on the correction of provider deficiencies. Following the facility's failure to satisfactorily meet this requirement, the Secretary could apply intermediate sanctions, but only after the Secretary has provided the facility with an opportunity to present its case at an informal hearing consistent with current practices. If the facility seeks further administrative or judicial appeals, the sanction would remain in effect while the appeals were pending.

(It should be noted that it is not the intention of the Committee that a decision to impose sanctions shall preclude whatever right to judicial review of disputes of fact concerning noncompliance with conditions of participation which a facility otherwise has.)

The Secretary would be required to provide public notification to potentially affected beneficiaries of the date the sanction takes effect and the fact that no benefits will be payable on behalf of a beneficiary admitted to the facility after that date. (Benefits would continue to be paid on behalf of beneficiaries who were inpatients of the facility prior to the designated date.) The Secretary would be required to promulgate regulations setting forth the procedures for implementing this provision.

The Committee believes that the application of this sanction, in lieu of immediate decertification of a facility where life and safety are not threatened, would serve to protect beneficiaries both by giving the skilled nursing facility an incentive to correct deficiencies in a timely manner and by forestalling the need for traumatic transfers of large numbers of patients during the time needed improvements are being made in the facility. However, the Committee believes that this sanction should not be used as an alternative in situations where a noncomplying facility's deficiencies place the health and safety of its patients in immediate jeopardy; instead, the response of the Secretary in such cases must be to deny all reimbursement of additional patients and to make appropriate arrangements for the orderly, planned transfer of existing patients.

It is recognized that several States presently have a full range of intermediate sanctions available, as part of their licensure authority, to impose against noncomplying facilities, including suspension of payments, bans on admissions, or even fines and penalties. The provision is not intended to limit or preempt such authority.

The section further authorizes the Secretary to make an independent and binding determination concerning the extent to which SNFs and ICFs that participate only in medicaid meet the requirements of participation in that program, and to terminate the eligibility of any facility that the Secretary finds does not comply with such requirements.

Under current law, the authority to determine whether an SNF or ICF that participates in medicaid but not medicare meets the requirements for participation in medicaid lies solely with the State medicaid agency. Based on current limited authority, the Secretary has issued regulations directed at assuring that States have followed Federal standards and norms in carrying out their survey and certification programs. However, the Committee is concerned that, without the authority to validate State agency compliance reviews and to make an independent judgment as to the extent of compliance by particular facilities, the Secretary lacks the means necessary to assure that Federal matching funds are being used to reimburse only those SNFs and ICF that actually comply with medicaid requirements.

The provision would accordingly provide the Secretary with the authority to "look behind" a State agency's compliance review of individual SNFs or ICFs. Where the Secretary determines that a facility has failed to meet the applicable requirements, then, the State agency's determination to the contrary notwithstanding, the Secretary would

be authorized to terminate the facility's participation in medicaid until the reason for the termination is no longer present and there is reasonable assurance that it will not recur. Under the section, termination could not take effect until the affected facility had been provided an opportunity for a hearing on the Secretary's determination that it failed to meet the requirements for participation.

LIFE SAFETY CODE REQUIREMENTS (SECTION 315)

The section authorizes the Secretary to determine in regulations when skilled nursing facilities participating in medicare and medicaid would be required to meet the provisions of revised editions of the Life Safety Code.

This provision would repeal the requirement of present law that a skilled nursing facility must meet the 1973 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) and allow the Secretary to establish the time frame for application of the latest edition of the Code. Since the Life Safety Code is revised by the NFPA approximately every 3 years to accommodate changes in technology or philosophy, the statutory requirement that facilities meet a specified edition of the Code creates unnecessary administrative complications and burdens on providers. Although a 1976 Code is currently in general use and a 1980 Code is under development medicare and medicaid facilities are still required by law to comply with the 1973 edition of the Code. To eliminate this discrepancy and to permit the flexibility necessary to adjust to scientific developments in the fire protection field, the section would allow the Secretary to revise the Life Safety Code requirement on a more timely basis without having to seek legislative changes. Moreover, such flexibility would reduce the regulatory burden on providers resulting from the application of unnecessary or out-of-date rules.

It is not the intent of the Committee's amendment that the Secretary select among provisions from more than one edition of the Code in determining LSC requirements. Rather, one edition of the Code, in its entirety, would be adopted. The Committee expects that normally, the latest edition would be the one required. The Secretary would have authority, however, to review each new edition of the Code to assure that its provisions continue to afford adequate protection for the health and safety of patients. The Secretary would also have authority to require adoption of a new edition of the Code within a reasonable time frame, consistent with the capabilities of the States to conduct the necessary surveys of facilities using the new edition of the Code. Moreover, the provision would not limit the Secretary's present authority to use, wherever appropriate, the equivalency standards developed by the National Bureau of Standards and incorporated by the NFPA as part of the Life Safety Code.

The Committee recognizes the potential for certain problems arising as a result of revisions embodied in later editions of the Code that may upset structural accommodations previously made by providers at some cost to them. The Committee expects the Secretary to be fully cognizant to the impact of such changes on providers and to take them into account in revising the Life Safety Code requirement. The intent of the change made by the section is to minimize regulatory burdens

on facilities, consistent with protection of the health and safety of patients and to assure orderly adjustments to changing technology.

CRIMINAL STANDARDS FOR CERTAIN MEDICARE- AND MEDICAID-RELATED CRIMES (SECTION 316)

The section provides that criminal penalties for solicitation or payment of kickbacks, bribes, rebates, or other remuneration in exchange for medicare or medicaid business apply only in cases where such conduct is undertaken knowingly and willfully.

Under current law, the solicitation or receipt of any remuneration in return for referring a medicare or medicaid patient to another party or in return for purchasing, leasing or ordering any service or supply covered under medicare or medicaid constitutes a felony, punishable by a fine of up to $25,000 or 5 years imprisonment, or both. The offer or payment of kickbacks, bribes, or rebates for such purposes is also a felony, punishable to the same extent. The Committee is concerned that criminal penalties may be imposed under current law to an individual whose conduct, while improper, was inadvertent. Accordingly, the section clarifies current law to assure that only persons who knowingly and willfully engage in the proscribed conduct could be subject to criminal sanctions.

EXCLUSION OF HEALTH CARE PROFESSIONALS CONVICTED OF MEDICARE OR MEDICAID RELATED CRIMES (SECTION 317)

Under the section, the provisions of present law relating to the exclusion from participation in the medicare and medicaid programs of physicians and other practitioners convicted of program-related crimes would be broadened so as to apply to other categories of health professionals, such as administrators of health care institutions.

Under present law, medicare and medicaid payment may be denied for goods and services furnished by a physician or other practitioner convicted of a program-related crime. However, similar action cannot now be taken with respect to other health professionals (such as operators or administrators of health care facilities) who are convicted of program-related crimes. The provision would rectify this deficiency in the law. In the case of those professionals who do not directly furnish medical care or services, payment would not be made to the provider for the cost of any services furnished to or on behalf of the provider by the convicted professional in connection with either program. (The provision of present law relating to a right to a hearing on a determination of the Secretary to bar an individual from participation would be retained.) The section also clarifies the intent of present law that the Secretary is authorized to bar a professional who may have participated only in the medicaid or medicare program from participation in both programs.

REQUIREMENTS CONCERNING REPORTING OF FINANCIAL INTEREST (SECTION 318)

The present statutory requirements relating to the reporting of financial interest as a condition of participation in medicare and medicaid would be amended by the bill to provide that an entity would

be required to report only those individual interests in mortgages or other obligations equal to at least $25,000 or 5 percent of the entity's total assets. Present law requires the reporting of all interests of 5 percent or more of any such obligation secured by property of the reporting entity, even where the obligation is secured by a small portion of the entity's assets.

The section would also clarify the states' responsibility to require compliance with the disclosure requirements of present law as a condition of participation in the medicaid program.

WITHHOLDING OF FEDERAL SHARE OF PAYMENTS TO MEDICAID PROVIDERS TO RECOVER MEDICARE OVERPAYMENTS (SECTION 319)

The Secretary's authority under present law to recover overpayments under medicare, where a provider has withdrawn or has been terminated, by withholding the Federal share of medicaid payments to the provider's would be extended by the section to instances where: (a) the provider continues to participate in medicare but at such a minimal level as to preclude recovery of the overpayment; and (b) where recovery of large medicare overpayments under part B to a physician or other health professional is precluded because the practitioner or professional is not participating in medicare (i.e., no longer accepts assignment for medicare claims).

Under present law, the Secretary can withhold the Federal share of medicaid payments from providers in order to recover medicare overpayments, but only where the provider has withdrawn or has been terminated from participation in the program. The purpose of this provision is to prevent such a provider from circumventing the intent of the recovery provisions of present law by formally maintaining its status as a participating medicare provider while substantially reducing its acceptance of medicare patients. Similarly, the section would permit recovery of medicare overpayments to physicians and professionals who subsequently elect not to accept assignment for medicare claims and thus preclude any recoupment of such overpayments through offsets against future medicare payments.

The Committee notes that it is not the intent of this section or the recovery provisions of the current law to penalize State medicaid programs by making them absorb the full cost of medicaid payments to these medicare providers who received overpayments under title 18. The Committee expects that the Secretary would provide adequate advance notice of no less than 60 days to the State concerning the providers who would be subject to the procedures for recovery of medicare overpayments through the withholding of the Fedral share of the medicaid payment, so that the State would have sufficient opportunity to change its payment procedures to these providers to insure that the reimbursement would be limited only to the State share of the bill.

HOSPITALS PROVIDING LONG-TERM CARE SERVICES "SWING BEDS" (SECTION 320)

The section authorizes the Secretary to enter into agreements with certain hospitals, for purposes of reimbursement under the medicare

and medicaid programs, under which the hospital could use its beds on a "swing" basis as either acute or long-term care beds, depending on need. A simplified cost reimbursement formula would avoid the current requirement for separate patient placement within the hospital and separate cost finding. (This formula would also reflect the lower cost of providing less than acute care.) Hospitals which have been granted a certificate of need for the provision of long-term care services would be eligible to enter into such agreements.

Where a hospital does not have such an agreement, payment for long-term care services furnished to a beneficiary who remains in the hospital because no long-term care beds are available in the community would be made at the average medicaid skilled nursing or intermediate care facility rate (as may be appropriate) if the hospital's average annual occupancy rate is below 80 percent and the hospital could obtain a certificate of need to provide long-term care services.

Patient days of care that are paid by medicare at the reduced rate would be counted against the beneficiary's eligibility for skilled nursing facility benefits. Similarly, the medicare skilled nursing facility benefit coinsurance rates would be applicable.

The Committee believes that a number of hospitals in areas where there is a scarcity of long-term beds could use their unoccupied acute care beds to provide a less intensive level of care. Under present law, however, such a lesser level of care furnished to medicare and medicaid patients in hospitals is not appropriately covered unless furnished in a distinct part of the hospital where beds are reserved solely for nursing care patients. The section would allow such hospitals to use their acute care beds to provide nursing care services which would otherwise be covered under medicare or medicaid if the services were provided in a skilled nursing or intermediate care facility. In order to assure the quality and appropriate use of such services, nursing care services provided to medicare and medicaid beneficaries in such a hospital would be subject to certain skilled nursing facility conditions of participation relating to social service staffing and functions and discharge planning that are not treated as specifically in the hospital conditions of participation. The conditions that the Committee expects the Secretary to apply include: (a) the social service provisions that require the facility to make an effort to identify the patient's social and emotional needs and to employ, or have a referral agreement with, a qualified social worker or social work agency; and (b) the requirement that the facility maintain an active discharge planning program. In addition, the Committee believes it would be desirable to encourage the facility's governing body to establish and direct the implementation of written policies regarding the rights of long-term care patients.

The Committee notes that this "swing bed" provision may not be appropriate under certain situations. A State in determining whether to issue a certificate of need for a hospital to provide long term care services should consider the cost of those services provided by a hospital compared to the cost of services which could be developed in a long term care facility. The role of the hospital and excess hospital capacity in this area must also be considered. It may be appropriate for a State to disapprove a certificate of need application from a hos-

pital in conjunction with this "swing bed" provision because the facility should close or convert some or all of its capacity to other uses. In this connection the committee looks favorably upon the idea of including in a hospital's reimbursement an allowance for the capital and increased operating costs associated with the closing or conversion of underutilized bed capacity or services in hospitals.

In order to avoid imposing a possible disadvantage on institutions that have established "distinct part" skilled nursing facilities, the section provides that the simplified "swing-bed" method of reimbursement would be made available under medicare and medicaid for services furnished in such "distinct part" facilities. The Secretary would approve this alternative reimburesment method where the hospital demonstrates that its use would contribute significantly to efficient and effective administration and would be in the interest of program beneficiaries. Making the simplified reimbursement option available would put institutions with distinct part skilled nursing facilities on an even footing with the other hospitals that will be eligible for "swing-bed" reimbursement under the bill.

Where continued hospital stay in an institution that has not entered into a "swing-bed" agreement with the Secretary is necessitated by the unavailability of an appropriate long-term care bed in the community, and (i) the hospital's occupancy rate is below 80 percent and (ii) it could obtain a certificate of need, payment would be made at the same rate otherwise payable to a participating "swing-bed" hospital. It is the Committee's intent that this second standard, i.e., that the institution could have obtained a certificate of need, would be considered met if the State Health Planning and Development Agency had found in its current State Health Plan that a shortage of nursing home beds existed in the area in which the hospital is located or if the agency determined that long-term care beds were not available in the area in institutions which would agree to accept medicare and/or medicaid reimbursement. It is not the intention of the Committee that the hospital must receive from the planning agency a formal decision relating to its specific case. Similarly, it is not the intent that the Secretary would be required to evaluate the local circumstances to determine if a certificate of need would have been given under State law.

In determining the appropriate rate of reimbursement for hospital patients receiving long-term care services where no swing-bed arrangement exists, the intermediary in the case of medicare or the State medicaid agency would be expected to determine on a case by case basis in accordance with standards established by the Secretary that no appropriate long-term care bed is available in an institution which will accept medicare and/or medicaid reimbursement. If it is determined that an appropriate long-term care bed is available, then the Committee expects that payment would not be made to the hospital for those patients needing only long-term care services (unless there was a swing-bed agreement or they were in a recognized distinct part). Further, the Committee notes that institutions which regularly receive payment for patients who do not need acute care but are receiving long-term care services in the hospital because no other bed is available in a skilled nursing facility should be encouraged to enter into a formal swing-bed arrangement.

If the hospital's occupancy rate is 80 percent or above, or it cannot obtain a certificate of need (presumably because there is a need for the hospital's acute care beds), payment would be made, as under present law, at the hospital rate for such period as it is medically determined the patient requires covered skilled nursing or intermediate care services and an appropriate bed is temporarily unavailable.

In adopting this provision, it is the intent of the Committee both to allow a more flexible situation for hospitals providing long-term care services when beds are not available in long-term care facilities and to reduce unnecessary expenditures at an acute care rate for hospital patients who are receiving only long-term care services. It is the Committee's intent that medicaid payments for such patients would also be reduced to the "swing-bed" rate. In past Court cases, decisions have been rendered requiring States to continue to reimburse at the acute care rate for patients in hospitals receiving only SNF services because no bed was available in a skilled nursing facility. At that time, the only reimbursement options were to pay the hospital rate or not pay at all. This section is designed to provide States the more reasonable standard of paying at the swing-bed rate, paralleling the medicare procedure.

COORDINATED AUDITS UNDER THE SOCIAL SECURITY PROGRAM (SECTION 321)

The section requires common audits of entities reimbursed on a cost-related basis under titles V (maternal and child health), XVIII (medicare), and XIX (medicaid), of the Social Security Act. The provision also requires the Secretary to undertake one or more demonstration projects with respect to such entities to determine the feasibility of a single coordinated appeal hearing to adjudicate disputed administrative cost items.

Currently, these programs generally provide for reimbursement of participating health care facilities on a reasonable cost or cost-related basis. To assure that payment of reasonable cost is achieved, a comprehensive provider audit program has been established. The medicare audits are mandated by law; the medicaid audits are required by regulation. At the present time, unless covered by a common audit agreement, providers have a separate audit conducted for medicare and medicaid. The duplicate auditing effort can be costly and time-consuming.

A voluntary common provider audit was established in 1968 by the Department of Health, Education and Welfare which established procedures to be followed, costs to be shared, method of payment for services and what coordination was necessary. Under the voluntary program, 37 States contracted with intermediaries for coordinated audits for some or all medicare—medicaid providers. Over half of the hospitals participating in Medicare were covered by those agreements. Under recently revised procedures authorizing freer exchange of audit information between the programs, all States have been negotiating new coordinated audit agreements with medicare intermediaries.

Under the new agreements, medicare will supply all of its audit information to the States free of charge. States will pay only the incremental costs to medicare intermediaries for auditing activities required

solely for medicaid purposes. The Committee would expect the Secretary to continue to follow this way of allocating costs when common audits are required.

Duplication of identical or similar auditing procedures used for the purpose of determining reimbursement under various Federal programs is costly to both the programs and the entities participating in the programs. In order to eliminate this duplication, the section requires that, if an entity provides services reimbursable on a cost-related basis under titles V or XIX, audits of books, accounts, and records of that entity are to be coordinated through common audit procedures with audits performed for the purpose of reimbursement under title XVIII. Where a State declines to participate in such common audits, the Secretary is to reduce payments that would have been made to the State under titles V or XIX by any amount in excess of the amount that would have been apportioned to the State if it had participated in the audit.

Duplication of procedures for hearing and adjudicating appeals from audit findings may also be unnecessarily burdensome and costly. The Committee's provision directs the Secretary to establish one or more demonstration projects to determine the feasibility of linking a common audit with a single coordinated appeal procedure.

DEMONSTRATION PROJECTS RELATING TO THE TRAINING OF AFDC RECIPIENTS AS HOME HEALTH AIDES (SECTION 322)

The section authorizes the Secretary to enter into agreements with up to 12 States, selected at her discretion, for the purpose of conducting demonstration projects for the training and employment of AFDC recipients as homemakers and home health aides. Ninety percent Federal matching would be provided under the States' medicaid programs for the reasonable costs (less any related fees collected) of conducting the projects. The projects would be limited to a maximum of 4 years plus an additional period of up to 6 months for planning and development and a similar period for final evaluation and reporting. The Secretary would be required to submit annual evaluation reports, and a final report on all the projects, to the Congress.

It has been estimated that as many as 40 percent of the aged and disabled now in high cost nursing care facilities do not necessarily have to be there—and would probably not be there if alternative supportive services to maintain them in their own homes were available. At the same time, there are many persons currently on the welfare rolls who, if they received appropriate training, could become gainfully employed members of ancillary health professions. The intent of the section is to permit the Secretary to undertake several demonstration projects to assess the validity of these assumptions and the potential savings to the medicare and medicaid programs of reduced use of institutional care.

A State participating in the project would be required to establish a formal program, approved by the Secretary, to train particiants in the provision of homemaker and home health aide services. The State would provide for the employment of those who complete the training program with public or (by contract) nonprofit private

agencies engaged in furnishing such services on a part-time or intermittent basis to aged, disabled or other incapacitated individuals who in the absence of such services might otherwise require institutional care.

AFDC recipients entering such a training program would be considered to be participating in a work incentive program authored under part C of title VI of the Social Security Act. During the first year such an individual is employed under the program, he or she would retain medicaid eligibility and any eligibility he or she had prior to entering the training program for social and supportive services provided under part A of title IV. Federal funding would not be available for the employment of any participant under the project after the participant has been employed for a 3-year period.

QUALITY ASSURANCE PROGRAMS FOR CLINICAL LABORATORIES (SECTION 323)

The section extends to December 31, 1980, the Secretary's authority to conduct a program to determine the proficiency of health care personnel, including clinical laboratory personnel, who do not meet formal educational requirements.

The Committee believes that proficiency examinations represent an effective mechanism for identifying competent health personnel who may lack the necessary credentials otherwise required under personnel standards contained in medicare's conditions of participation.

REIMBURSEMENT OF CLINICAL LABORATORIES UNDER MEDICARE AND MEDICAID (SECTION 324)

The section places limitation on reimbursement for markups on clinical laboratory services billed by physicians under medicare and medicaid and authorizes State medicaid agencies, on a demonstration basis, to purchase laboratory services through a competitive bidding process. The provision further directs the Secretary to evaluate and report to Congress on the impact of these policy changes. It also clarifies the requirement that all clinical laboratories furnishing services for which payment is claimed under medicaid must meet the medicare standards for participation.

Under current law, the medicare and medicaid programs may make payment for clinical laboratory services to hospitals, to physicians, or directly to independent laboratories; medicare can also make payments directly to patients. When the payment is to the physician, it may be for a test performed in his office, or it may be for a test which he sent out to an independent laboratory, which then billed the physician for the work. There is evidence, documented in GAO reports, that in some cases, the physican bills the patient (or the medicare or medicaid programs) for the test that was performed by the independent laboratory at rates greatly in excess of what the laboratory charged the physician for the work.

The section addresses this problem of substantial markups of bills for laboratory services where the bill is submitted by the physician but the laboratory services are not performed by him. The bill provides that when a physician includes an amount in his bill for laboratory

services, he must indicate either (i) that he or another physician in his office personally performed or supervised the laboratory services, or (ii) the name of the laboratory performing the services and the amount the physican was billed by the laboratory.

If the physician fails to provide the necessary information, the payment allowed for the laboratory services included in his bill will be limited to the charge estimated by the medicare carrier to be the lowest charge at which the services could have been secured by a physician from a laboratory serving the applicable locality. This provision is designed to serve as an incentive to the physician to provide the necessary information on laboratory services included in his bill, so that it can be determined that the laboratory doing the work is one that meets appropriate standards, and so that the program administrators can be certain that there is no unreasonable markup in the charge. Under current program requirements, physicians are required to provide similar information, but often do not. Medicare carriers find it impossible to follow up on all bills where the information is not included. This provision will provide authority to limit payments in these situations.

If the physician does indicate on his bill that the laboratory service was performed elsewhere, and indicates which laboratory performed the service and how much they billed him, the allowed payment will be the lower of that laboratory's reasonable charge (subject to the usual requirements of the law for determining reasonable charge) or the amount actually billed the physician, plus a nominal fee to cover the physician's costs in collecting and handling the sample. The Committee intends this fee be limited to the minimum amount generally necessary to cover physicians' actual costs of collecting and handling samples on which tests are performed.

The Committee expects this provision to result in lower program payments in many instances, because it is not uncommon for a laboratory to bill a physician less than its reasonable charges. This provision will assure that the programs will benefit from the discounted rate.

If the physician's bill indicates the laboratory service was performed by the physician or another physician with whom he shares his practice, or by someone under their supervision, the reimbursement allowed would be the physician's reasonable charge for that service (again, subject to the applicable provisions of the law regarding reasonable charge). The committee notes that use of the phrases "supervised the performance of such services" or "supervised such services" would not require that a physician personally supervise the performance of each test for which a bill has been submitted. The physician would be expected to exercise general supervisory responsibility. (In all cases, the amounts reimbursable under medicare are subject to applicable deductible and coinsurance requirements).

While the committee has determined that these limitations on payments for laboratory services are appropriate, there is concern that the reduction in reimbursements may fall on the patient rather than on the physician who fails to provide the required information on the laboratory services or who is engaging in excessive markups. The structure of the medicare program, under which many physicians do not take assignment and bill the program directly, results in many

patients paying the physicians' fees and then submitting the bill to medicare. In this situation, there is a potential for the patient rather than the physician to feel the effect of the medicare policy to limit payments for laboratory services. The committee has determined that there cannot be justification for continuing a policy of paying excessive markups on laboratory tests because the failure of physicians to take assignment might result in the lower reimbursement going to the patient rather than the physician. However, the committee has directed the Secretary of Health and Human Services to report to the Congress within 2 years on the experience with this provision, particularly in regard to how frequently the reduction in the allowed amount has resulted in lower payments to the patient rather than to the physician. This information will allow determination of whether further legislative change to protect the patient is necessary. Additionally, the Secretary is required to report on the savings in expenditures for laboratory services which have resulted from this provision.

Under the medicaid program, a State has the authority to require that all bills for laboratory services be submitted directly by the practitioner or entity performing the service. The provision leaves that option to the States; however, if a State opts instead to allow indirect billing, it is required to assure that reimbursement does not exceed the amount that would be allowed under medicare. To assure this, a State would have to require the physician to submit information essentially similar to the information required by medicare.

Under current medicaid law, program eligibles are entitled to obtain covered services from the provider of their choice. This freedom of choice requirement poses a bar to State or local efforts to limit the number of clinical laboratory service providers participating in medicaid through a competitive bidding process. The committtee has concluded that the freedom-of-choice concept has little real applicability in the case of laboratory services where the patient, in fact, does not "choose" his provider in any real sense. Further, the committee notes that GAO has found that, even though medicaid programs are high volume purchasers of clinical laboratory services, State often pay higher prices for such services than other purchasers. Based on these findings GAO recommended that competitive bidding for medicaid laboratory services be tried on an experimental basis.

The provision allows States (or parts thereof) to purchase laboratory services for a 3-year period under arrangements which would not be subject to the general freedom of choice requirements of the medicaid law, provided that the Secretary of Health and Human Services approved the plan. The Secretary would determine that services would be purchased only from laboratories that met standards, and that the prices charged the program would not exceed the lowest amount charged to others for similar tests, or, if the purchasing arrangements were agreed to on some unit price basis, that the aggregate expenditures would not exceed the aggregate expenditures that would have been anticipated if each test was charged at the lowest rate charged to others for that test. Additionally, the Secretary must be satisfied that under the arrangement adequate laboratory services would be available to the physicians and other providers treating medicaid patients; the committee has required that the Secretary may approve State plans only when these conditions are met.

The committee is concerned, however, that concentration of medicaid business in a small number of laboratories might prove detrimental to quality if the laboratory served only the medicaid population. The committee believes it would be beneficial to make arrangements for the purchase of services only with laboratories that provide services to both private and public patients. Providers of laboratory services to the general population have established fee schedules for their services and often have operational quality assurance mechanisms, thus providing the purchaser with a ready means of determining the lowest rate charged for quality services. The committee does not wish to take any action which would result in the development of a two-class system of health care in this country by allowing States to purchase laboratory services from providers whose only customer is medicaid. Experience has generally shown that the existence of a private clientele has a quality assurance effect on the services provided to public patients. Therefore, the committee has established as an additional condition for approval of a State plan for the purchase of laboratory services that no more than 75 percent of the laboratory's business may be with medicaid and medicare patients.

The committee recognizes that one result of this legislation will be a reduction in the number of providers from whom a State, or political subdivision, purchase laboratory services. Theoretically, it would be possible for a State or political subdivision, under this act to enter into arrangements with only one provider of laboratory services in an area (provided the condition of adequate available services was met). The committee's intent, however, is not to encourage such a monopolistic situation in any large health care delivery area. Obviously, in such an area it is more desirable to encourage the utilization of several providers. It only one provider is serving a very large population group, the State could become the "captive" of the provider and find it administratively difficult to switch to another provider should the first prove to be inadequate or to charge excessive rates. In addition, accessibility of the services to the physician should be a consideration in determining the number of such arrangements. Therefore, it is the committee's expectation that States making arrangements with providers of laboratory services under this legislation would generally not make such arrangements with only one provider of such services in any large health care delivery area. Furthermore, the Secretary in establishing policies and rules to implement this provision should discourage such monopolistic situations.

Although the committee is persuaded that an override of the freedom-of-choice provision of medicaid is justified in the case of laboratory services, it recognizes that unanticipated problems may result when this policy is implemented. Consequently, the committee has limited the time period during which States may purchase laboratory services through these arrangements to 3 years, and has instructed the Secretary of HEW to evaluate experience with the new arrangements, and report to the Congress within 24 months on the results so that determination of whether the policy change should be permanent can be made.

Finally, the provision clarifies the legislative authority for the current requirement in regulation that medicaid laboratories must meet

the same standards required for laboratories participating in the Medicare program.

REIMBURSEMENT OF PHYSICIANS' SERVICES IN TEACHING HOSPITALS (SECTION 325)

The section authorizes reimbursement under Medicare and Medicaid to hospitals with approved teaching programs for services rendered by physicians if the hospital so elects and if all physicians agree not to bill program eligibles for professional services rendered in the hospital; otherwise, physicians in teaching hospitals would be eligible for reimbursement directly under the physician payment provisions of Medicare and Medicaid. The section also repeals certain provisions of 1972 amendments to the Social Security Act relating to payment of teaching physicians that were never implemented through regulation.

The medicare program, Title XVIII of the Social Security Act, is comprised of two complementary programs—the Hospital Insurance program which generally pays for institutionally provided services. such as hospital care, and the Supplementary Medical Insurance program which pays for physician, diagnostic, and ambulatory services. This structure raised several administrative questions when applied to the nation's teaching hospitals where the physicians provide both professional medical services to individual patients and educational and supervisory services to the hospital itself. Essentially, the bipartite structure of the medicare program necessitated that the dual activities of these teaching physicians be clearly separated for reimbursement purposes between the Hospital Insurance and Supplementary Medical Insurance components of medicare. In the early years of the medicare program, this separation was not effectively accomplished in some teaching hospitals.

The Social Security Amendments of 1972 (Public Law 92-603) included a provision (section 227) which was intended to assure that medicare would make charge reimbursement for physician services furnished in teaching hospitals only if its beneficiaries received bona fide private patient care. This was believed to be necessary because the General Accounting Office and other investigators found that some teaching physicians billed for services actually furnished by interns or residents who assumed responsibility for the treatment; in other cases, physicians' charges were out of proportion to the physician services actually rendered or the charges billed to other patients. Section 227 generally treated physician services furnished in teaching hospitals as hospital services, reimbursable to the hospital on the basis of reasonable costs. However, two exceptions were permitted to this general rule: Charges were payable for physician services furnished in certain hospitals which had traditionally billed and collected for physician services on a charge basis; charges were also payable if a hospital's patients were private patients, with "private patient" to be defined in regulations by the Secretary. Implementation was scheduled for hospital cost reporting periods beginning after June 30, 1973.

However, to date, implementation has not occurred. Initially, section 15 of Public Law 93-233 delayed implementation so that the Institute of Medicine of the National Academy of Sciences could

study and report on reasonable and equitable methods of reimbursing for physician services in teaching hospitals. (Section 15 also provided that hospitals could elect cost reimbursement for their physicians' services if all the physicians in the hospital agreed not to bill charges for services furnished to medicare patients. A small number of teaching hospitals have elected to be paid for physician services on this cost basis.) The Institute of Medicine study was issued in March 1976. The changes proposed by section 227 were to have taken effect on October 1, 1978. However, the Secretary has still not issued a notice of proposed rulemaking to implement the section 227 changes.

The Committee believes that no purpose would be served by further postponement of the effective date. The current situation results in uncertainty for providers and physicians concerning what the standards for reimbursement will be. Further, the Committee has reluctantly concluded that the current provision is apparently unadministrable. Additionally, the committee believes that there have been significant changes in the way services are furnished in teaching hospitals since enactment of section 227. Intermediary Letter No. 372, issued in April of 1969, established clearer criteria for identifying the personal identifiable services a teaching physician must perform for an individual patient to qualify for a fee-for-service payment under the Supplementary Medical Insurance component of medicare. When these criteria are not met and properly documented in the medical record, it is presumed that the physician is provided only educational or supervisory services, and the costs of the service are included in the reimbursement from the hospital component of medicare. The patient care requirements of Intermediary Letter No. 372 seem to have been accepted by teaching physicians and adopted as policy by teaching hospitals.

The provision, therefore, would permit physicians to continue to be reimbursed on a charge basis, unless the teaching hospital and all its physicians elect to be paid on the basis of reasonable cost (as previously permitted by section 15 of Public Law 93–233 on an interim basis), with the understanding that as a minimum the guidelines currently in effect governing payment for physicians' services in teaching hospitals, which this Committee endorses, will remain in effect. Further, this Committee expects that HEW will take steps forthwith to incorporate these guidelines in its regulations. Physicians, teaching hospitals, and related entities should recognize that the Committee's action is not an invitation to return to any abuses of the late sixties. The Committee strongly believes teaching physicians should personally perform or personally supervise patient services in order to qualify for fee-for-service payment. The Committee notes that failure of a physician, teaching hospital, or related entity to comply with these requirements would, among other things, constitute a false statement or representation of a material fact in an application of payment under medicaid or medicare. The Committee expects the Department and State Medicaid fraud and abuse control units to vigorously pursue any noncompliance.

Where States elect to compensate for services of teaching or supervising physicians under medicaid, Federal matching should be limited to payments not in excess of medicare allowances.

The provision would be effective with cost reporting periods beginning on or after October 1, 1978.

DEMONSTRATION PROJECTS FOR REQUIRING SECOND OPINIONS FOR CERTAIN ELECTIVE PROCEDURES UNDER MEDICARE AND MEDICAID (SECTION 326)

The section authorizes the Secretary to undertake, through grant or contract, demonstration projects to determine the cost-effectiveness and effect on the patient of mandating that medicare and medicaid beneficiaries obtain a second opinion with respect to certain elective surgical procedures before payment will be made for those services. The section also provides that no medicare or medicaid beneficiary may be required to participate in a demonstration project for requiring second opinions for certain elective surgery without his or her informed consent.

Under current law, persons eligible for benefits under medicare and medicaid are entitled to have payment made for medically necessary physicians' and hospital services, including medically necessary elective surgical procedures. If program eligibles voluntarily seek second opinions from another physician before undergoing elective surgery, reimbursement is made for those consultants, subject to applicable cost-sharing requirements.

The Committee believes that second opinion programs may be of great value in reducing unnecessary surgery, in reducing unnecessary expenditures (both by Government and consumers), and by enabling consumers of medical care to make better informed choices as to their own well-being.

In hearings held by the Committee's Oversight and Investigations Subcommittee in 1975, 1976, 1977, and 1978 (resulting in reports in 1976 and 1979) and in hearings held by the Health and Environment Subcommittee in 1979, Eugene McCarthy of Cornell Medical School has presented eight years of data and follow-up on both mandatory and voluntary second opinion programs. That data has indicated the potential worth of second opinion programs. The Oversight and Investigations Subcommittee has also had independent confirmation of McCarthy's results from Canadian and U.S. board certified surgeons acting as consultants to the Subcommittee on the subject of hysterectomies and tonsillectomies.

In order to determine the relative effect of a mandatory second opinion program rather than the voluntary program of current law, the section directs the Department of Health, Education and Welfare to fund at least seven 2-year demonstration projects. These demonstrations would examine the effects of requiring a second physician's opinion on the rate and cost of selected elective surgical procedures funded by the medicare and medicaid programs. The Secretary of HEW would request proposals from public or private entities (PSRO's, Medical Societies, state agencies, etc.) covering populations of sufficient size to provide statistically significant data. Submitted proposals would be considered according to criteria determined by the Secretary and would, as far as possible, include rural and urban populations and several economic strata.

Under the provisions, the Secretary may fund a project only if it includes satisfactory procedures for notifying both patients and

physicians of the existence and requirements of the project and to the extent practicable for preventing the physician providing the second opinion from knowing the identity of the physican offering the original opinion. It is the intent of the Committee that the Secretary assure that payment will be made for the second opinion only if the physician providing that second opinion is independent of the first physician and has no financial arrangements with him or her. Further, the section requires that individuals must be provided with a list of physicians who will provide written second opinions. The Committee believes the program should not be carried out in health manpower shortage areas where there would be an insufficient number of physicians to give second opinions or where requiring second opinions would worsen the problem of securing necessary medical services which are already in short supply.

Patients in the demonstration areas who agree to participate in the project would be required to have a second opinion before medicare or medicaid would pay for the surgical procedure. Medicare or medicaid would pay the full cost of this additional benefit. Medicare or medicaid reimbursement would be dependent on obtaining the second opinion and payment would be made for the surgical procedure according to regular program rules if the patient made the final decision to have surgery, whether or not the first and second opinions were not in agreement. A patient could obtain a third opinion, if he wished, when the first and second opinions did not concur. Emergency or urgent surgery would not require a second opinion.

An evaluative component would be built into the demonstration projects to provide statistically valid data on the following: (1) effect on number of procedures performed, (2) savings of items such as direct and indirect surgical costs, (3) additional medical costs incurred, (4) administrative costs, (5) administrative complexities of a required program, (6) health status of patients in relationship to whether or not they had a surgical procedure and (7) additional information obtained by the patient from a second physician's opinion. Existing data is insufficient to determine the effect of a mandatory second opinion program on these variables.

The number of patients receiving second surgical opinions under this type of program is expected to exceed those reached under a voluntary program thus providing data to evaluate the effect of the second opinion program in terms of the criteria described above, when it is used by a large number of patients who are not self-selected.

Under current law, research, development, and related activities funded by grant or contract through the Department of Health and Human Services that would place human subjects at risk are required to meet regulatory standards designed to assure the protection of those subjects. Among these protections is the requirement that the activity obtain the legally effective informed consent of an individual before involving him or her as a subject.

The Committee does not believe that the demonstration projects for requiring second opinions for certain elective surgery authorized by the bill would place medicare or medicaid beneficiaries at risk. However, the Committee does feel that medicare and medicaid beneficiaries should not be subject to such a demonstration project without their written and legally effective informed consent. The section provides

that, before payment for an elective surgery can be denied under a demonstration project for failure by the beneficiary to obtain a required second opinion, the beneficiary must have given, in writing, his or her informed consent to participate in the project.

Under the provision informed consent must be knowingly and freely given by the individual (or his legally authorized representative), without undue inducement and without constraint or coercion in any form. In order for the consent to be informed, each individual must receive a fair explanation of the nature and purposes of the project, a description of the risks and benefits that can reasonably be expected from participation in the project, a disclosure of any appropriate alternatives to participation that might be advantageous to the individual, and an offer to answer any questions the individual might have with respect to the project.

The Committee notes that since the purpose of these projects is to determine the differential costs and effects of a program where the receipt of the second opinion is required before the elective surgery is paid for rather than something that may be done at the option of the individual when the initial opinion recommending surgery is received, the Secretary would be expected to receive some assurance in regard to a given project that sufficient numbers of persons would consent to participate (and agree to the requirement of a mandatory second opinion) before the project would be funded. The Committee would expect, then, that the consent would generally be sought prior to an occasion when the initial recommendation for surgery is made. However, once a sufficient level of participation is assured, at the option of the project and the Secretary, further participants could be allowed to enter the project if they are willing to give their informed consent to participate at the point when the recommendation for one of the elective surgical procedures is made.

CONTINUED USE OF DEMONSTRATION PROJECT REIMBURSEMENT SYSTEMS (SECTION 327)

The section authorizes States with rate-setting programs for the payment for hospital services that have been approved as demonstration projects by the Secretary to continue to determine medicare and medicaid reimbursement rates for hospitals under those programs unless the Secretary finds that the program no longer needs applicable standards.

Under current law, hospitals participating in medicare and medicaid are generally reimbursed on a "reasonable cost" basis for covered inpatient services. The Secretary has the authority to approve the use of alternative reimbursement rates or methodologies in connection with demonstration projects to determine whether the alternatives will increase the efficiency and reduce the costs of providing hospital services under medicare and medicaid without adversely affecting the quality of services provided. Four major projects in Maryland, New York, New Jersey, and Washington are currently operating under this demonstration authority.

While the Secretary has authority to determine the appropriate length of a demonstration project sufficient to carry out the purposes of the demonstration, she does not have the authority to extend dem-

onstration projects indefinitely. As a result, several States now operating approved programs are in jeopardy of losing their authority to determine medicare and medicaid rates for hospital services on other than a "reasonable cost" basis, even though the programs have effectively restrained the rates of increase in the cost of hospital services. The loss of this authority would have a severe and adverse impact on the ability of the affected States to carry out their hospital cost containment efforts and might lead to increased Federal medicare and medicaid outlays as well.

The provision authorizes the Secretary to continue to allow medicare and medicaid reimbursement to be made under a reimbursement system originally established on a demonstration project basis after the demonstration period has ended. The demonstration projects must have been approved by the Secretary under section 402 of the Social Security Amendments of 1967 as amended by Section 222(b) of the Social Security Amendments of 1972, or Section 222(a) of the Social Security Amendments of 1972, and the rate of increase in the costs per admission of medicare patients during the course of the project must have been less than or equal to the rate of increase for all medicare beneficiaries during that period. If these conditions are met, and if the State has legislative authority to operate such a system (and the State elects to have reimbursement made under the system) or the system is operated through a voluntary agreement of hospitals (and those hospitals elect reimbursement under the system), then the Secretary must continue to allow medicare and medicaid rates to be established through the rate-setting system.

Under the section, use of the demonstration project reimbursement system would continue until the Secretary determines that all third party payers do not reimburse participating hospitals on the basis required under the system, or that the rate of increase in costs per admission of medicare patients in the participating hospitals when measured over the previous three year period, exceeds the comparable rate of increase in costs per admission for medicare patients in all hospitals throughout the country. These limitations on the State's continuing authority are intended to insure that the medicare program does not pay more for hospital services under the State's system than under the "reasonable cost" payment method.

The Committee would expect the Secretary to develop a process for reviewing and validating the performance of the system, and for monitoring any changes in the plan. It is not the intent of the Committee to freeze the system in place in exactly the form approved as part of the demonstration if improvements can be made; however, it is the intent that the program would continue to operate in basically the same form so that the Secretary is assured that its effectiveness is not impaired, and that additional costs are not shifted to medicare or medicaid.

REIMBURSEMENT FOR HEALTH MAINTENANCE ORGANIZATIONS (HMO'S) (SECTION 328)

The section would provide reimbursement for health maintenance organizations on the basis of a prospectively determined per capita amount equal to 95 percent of the cost of providing medicare benefits

would not be required to be reviewed under Section 1527 of the Public Health Service Act.

This section does not impose any new requirement for review under Section 1122. For services which are not required by Title XV to be included in a state certificate of need program, such as home health services, those services would only be reviewed under Section 1122 if the section provided for such review.

REIMBURSEMENT UNDER MEDICAID FOR SERVICES FURNISHED BY NURSE MIDWIVES (SECTION 331)

The section requires States to provide coverage under their medicaid programs for services furnished by a nurse-midwife to the extent that he or she is authorized to perform such services under State law or regulation. The section would authorize reimbursement on either an indirect or direct basis and would empower the Secretary to establish standards for nurse-midwife participation in medicaid.

Under current law, States may, at their option, provide coverage under their medicaid programs for nurse midwife services. They may recognize these services as within the scope of physicians' services, clinic services, or hospital services; in this case, payment is made to the physician, clinic, or hospital for which the nurse midwife is employed or otherwise associated. States also have the option of paying for these services by directly reimbursing the nurse-midwife who furnished them; the Committee is informed that only two States currently reimburse directly. In addition, medicaid law requires States to cover rural health clinic services, which include care provided by a licensed nurse midwife employed by, or receiving compensation from, a qualified rural health clinic (reimbursement is made to the clinic).

Nurse midwives are registered nurses with additional educational and clinical backgrounds in midwifery. Within the scope of their authority under State law or regulation, nurse midwives manage the care of normal mothers and newborn babies throughout the maternity cycle—pregnancy, labor, birth, and the immediate post-partum period—with various arrangements for physician referral and consultation in the event of complications. The Committee is informed that all but 3 States have laws or regulations authorizing or permitting the practice of midwifery.

The Committee heard testimony that nurse-midwives represent a cost-effective source of quality maternity care. In order to increase the availablity and accessibility of nurse-midwives to low-income women eligible for medicaid, the provision requires State to provide coverage for nurse-midwife services to the extent that the nurse midwife is authorized to practice under State law. Reimbursement would be available whether or not the nurse midwife was under the supervision of, or associated with, a physician or other health care provider. It should be stressed again, however, that the provision would not preempt State law or regulation relating to the legality or scope of practice of nurse-midwives.

The Committee notes that as a result of making coverage of the services of a nurse midwife mandatory in the medicaid program, States would be required to offer direct reimbursement to these health care

practitioners as one of the available payment options. As is generally the case under the medicaid program, each State would establish its own reimbursement level for these services, subject to the test of current law that reimbursement be sufficient to assure that the service is actually available (where there are nurse midwives).

In order to qualify as a nurse-midwife for purpose of receiving medicaid reimbursement, a registered nurse would either have to be certified by an organization recognized by the Secretary or have successfully completed a program of study and clinical experience that has been approved by the Secretary. In implementing these requirements, the Secretary is expected to provide for the establishment of standards that will assure that medicaid eligibles will receive high quality care without creating unnecessary barriers to entry for qualified nurse midwives seeking to participate in medicaid.

CONTINUING MEDICAID ELIGIBILITY FOR CERTAIN INDIVIDUALS BY DISREGARDING CERTAIN INVOLUNTARY INCREASES IN INCOME (SECTION 332)

Under the section, any cost-of-living or annual, general increases received by medicaid beneficiaries in Social Security, Railroad Retirement, Civil Service Retirement, or Veterans' benefits would be disregarded for purposes of determining their eligibilty for continuing medicaid coverage. This disregard would apply only to individuals who were eligible for medicaid on or after June 1, 1980, and who would lose their medicaid eligibility as a result of any such cost-of-living or annual increase.

Under current law, persons who receive cost-of-living or annual increases in Social Security benefits, Railroad Retirement benefits, Veteran's benefits, or Civil Service Retirement Benefits must accept those increases as a condition of medicaid eligibility. Generally, any such increases are included in the incomes of these persons for determining whether they meet, or continue to meet, the applicable State medicaid income standards. When these increases are counted, a person may lose medicaid eligibility even though the increase in income almost certainly is not sufficient to replace the value of the lost medicaid coverage. In the Unemployment Compensation Amendments of 1976, Public Law 94–566, Congress provided protection against loss of medicaid for persons who were receiving both Social Security and Supplemental Security Income (SSI) cash benefits, but who lose their SSI eligibility as a result of a cost-of-living increase in Social Security benefits. However, this protection did not extend to persons who were not actually receiving SSI payments (residents of nursing homes, for example, or medically needy persons), or to persons who received annual or cost-of-living increases in Railroad Retirement, Veterans' or Civil Service benefits.

The Committee believes that congressionally mandated increases in Social Security, Railroad Retirement, Veterans', or Civil Service Retirement benefits should not inadvertently penalize the low-income beneficiaries of those programs by terminating their eligibility for medicaid. The purpose of these cost-of-living or annual increases is to enhance the ability of these indigent beneficiaries to meet their subsistence needs; by resulting in the loss of medicaid eligibility, however, these increases have precisely the opposite effect.

EXTENSION OF INCREASED FUNDING FOR LONG TERM CARE FACILITY INSPECTORS UNDER MEDICAID (SECTION 335)

The section would extend through fiscal year 1983 the current federal matching rate of 100 percent for the costs of State long-term care facility inspections.

Under current law, skilled nursing facilities (SNFs) and immediate care facilities (ICFs) participating in medicaid are required to meet staffing, licensing, life safety, and various other health and safety standards. To encourage States to devote adequate resources to the inspection of SNFs and ICFs and assure conformity with these requirements, the Federal Government now pays 100 percent of the costs of training and compensating personnel responsible for such inspections. This 100 percent matching rate for medicaid inspections is due to expire on September 30, 1980; thereafter, the Federal matching rate would drop to 75 percent, the rate which otherwise applies for State administrative costs involving skilled medical personnel, and the rate that was in effect for long-term care facility inspections prior to passage of the Social Security Amendment of 1972.

The Committee is concerned that, should the scheduled decrease in Federal matching payments take effect, some States might respond by reducing personnel, thereby weakening their inspection and enforcement efforts and possibly jeopardizing the health and safety of program eligibles receiving long-term care in participating SNFs and ICFs. Accordingly, the section would extend the current 100 percent matching rate for an additional 3 years. The Committee stresses that, in accepting this Federal financial assistance, States are subject to the provisions of Title VI of the Civil Rights Act of 1964 which, among other things, prohibit discrimination in connection with the employment of inspection personnel on the basis of race, color, or national origin. Additionally, the Committee notes its strong belief that the political affiliation of such personnel should not have bearing on employment; and to take this into account where Federal funds are supporting 100 percent of the costs of these personnel would be counter to the intent of the Committee in recommending this bill.

While some have urged that the 100 percent matching rate be extended on a permanent basis, the Committee has determined that a limited extension would be more appropriate at this time. The Committee is concerned that some of the State inspection programs may not be as effective as the Committee would expect in assuring safe conditions or quality care in participating SNFs and ICFs and may be excessively costly to the Federal government. It is the Committee's intention to request the Comptroller General to investigate the effectiveness of State inspection programs funded under this provision and to make recommendations to the Congress before any further extension in the 100 percent matching rate would be considered.

EXTENSION OF INCREASED FUNDING FOR STATE MEDICAID FRAUD CONTROL UNITS (SECTION 336)

The section authorizes Federal matching payments to the States for the costs of establishing and operating medicaid fraud control units at the rate of 90 percent for an initial 3-year period and 75 percent

thereafter. These payments would be subject to a ceiling of the higher of $125,000 or one-quarter of 1 percent of total medicaid outlays in the State in the previous quarter.

Under current law, Federal matching payments are available to States that establish agencies to investigate and prosecute fraud in their medicaid programs. To encourage the development of such medicaid fraud control units, Congress in 1977 provided that States would be reimbursed for 90 percent of the start-up and operating costs. This 90 percent matching rate was made available for only three years; it is scheduled to expire on September 30, 1980. Thereafter, the Federal matching payment will drop to 50 percent, the usual rate provided in the medicaid program for administrative costs.

The Committee is informed that some 28 States now have medicaid fraud control units in place and that another 13 States are in the process of developing such a capability. However, some of the States that wish to establish such units have experienced delays in doing so and, under current law, would not be able to realize the full benefit of the increased Federal matching rate. The section would eliminate this artificial deadline and substitute a Federal matching arrangement of 90 percent for a 3-year period and 75 percent thereafter. Thus, regardless of when a State began to develop its medicaid fraud control unit, it would be eligible for up to 3 years of Federal funding at the 90 percent matching rate. It should be understood that this provision would not give States an additional three years of 90 percent Federal funding if they have already been receiving the higher matching payments; the total time a State could draw the 90 percent would be measured from enactment of the original provision. After three years of 90 percent funding, the rate would drop to 75 percent, a level designed to provide a continuing incentive for operation of these units. As under current law, Federal matching payments in any calendar quarter would be limited to the greater of $125,000 or $0.25 percent of the total medicaid outlays in the State for the previous quarter.

The Committee believes that expenditures to assure the development and continued operation of effective State fraud units constitute a highly effective use of Federal funds. The Inspector General has estimated that without a continuation of the higher Federal matching rate, some existing State fraud agencies would cease operation and other States now interested in establishing units would not do so. Although there is little question that most units are clearly cost effective, without the special Federal funding, there is a concern that bureaucratic pressures and inertia within a State might result in the medicaid agencies simply absorbing the anti-fraud activities into their already numerous functions, with a loss of effectiveness in criminal investigation and prosecution activities, for which the independent anti-fraud agencies are better suited.

CHANGE IN CALENDAR QUARTER FOR WHICH SATISFACTORY UTILIZATION REVIEW MUST BE SHOWN TO RECEIVE WAIVER OF MEDICAID REDUCTION (SECTION 337)

The section prohibits the Secretary from assessing financial penalties against States for failures to meet the requirements of medicaid law

regarding utilization review of long-term care services in institutional settings for periods before January 1, 1978.

Under current law, States must, as a condition of participation in medicaid, have an adequate program of control over the utilization of institutional services, including reviews of the necessity for the admission and continued stay. Failure to meet these requirements subjects a State to a one-third reduction in Federal matching payments for long-term stays in institutional settings.

In 1977, after years of inaction, the Secretary assessed penalties against a number of States under this provision. The severe and unanticipated impact on affected State medicaid programs led Congress, in Public Law 95–142, to allow the States additional time to bring themselves into full compliance with the utilization control program requirements and to waive penalties assessed for past periods against any State demonstrating full compliance by December 31, 1977.

For technical reasons, the State of Colorado is, under current law, still subject to retroactive penalties. Since the Committee believes the State has complied with the spirit of Public Law 95–142, the section would direct the Secretary to waive any financial penalty assessed against a State with respect to periods before January 1, 1978, if the State is able to show to the Secretary's satisfaction that it was in compliance on or before December 31, 1978. The Committee emphasizes that this technical change is in no way to be viewed as a retrenchment or a lack of resolve on its commitment to effective utilization control and medical audit programs under medicaid. It fully expects and intends that Colorado and all other States participating in medicaid will take the necessary steps to remain in full compliance.

EXPEDITED RECOVERY FOR CERTAIN DISALLOWED MEDICAID CLAIMS (SECTION 341)

The section provides for recovery by the Department of Health and Human Services of Federal matching payments for State medicaid expenditures which are disallowed on or after October 1, 1980; the section provides that the recovery will be made by offsetting payments to the State which occur subsequent to the final notice of disallowance. The section provides that the Secretary shall give a preliminary notice to the State of her intention to disallow payments at least 30 days prior to the date of the final notice of disallowance. Further, it provides that if the Secretary's disallowance is overturned through regular administrative or judicial appeals, the State shall be paid the amount disallowed plus interest.

Currently, when HHS makes a finding that a State claim for Federal matching funds should not have been allowed, it does not recover the Federal funds already granted to the States until the appeals process is completed, which typically takes as long as two years. During this period, the money is not returned to the Federal Government, and any interest that accrues is retained by the State. This provision would reverse that procedure. Th Federal Government would recover the amount of disallowed funds out of the next grant award. Under the provision, if the State appeal is eventually upheld, the Federal Government is required to return the disputed funds to the State plus interest.

It is the Committee's intention that this provision should apply only to future findings of disallowance. It is not the intention to affect amounts already involved in the appeals process. Further, the section provides for a preliminary notice by the Secretary to a State indicating her intention to disallow certain expenditures. In requiring that at least 30 days must elapse before the final notice of disallowance is issued, it is the intent of the Committee to allow the State opportunity to present to the Department any additional information which may be relevant. This opportunity for an informal appeal thus occurs before the final notice of disallowance is made and the formal appeals process is begun.

In order to assure that the Secretary does not exercise the disallowance authority in an arbitrary manner, the section provides for repayment to the State with interest of any amounts disallowed by the Secretary where the Secretary's finding is later overturned, either through administrative or judicial appeals. The Committee intends for a similar procedure to be applied if the amount of the disallowance is reduced.

B. Cost Estimate

The Committee concurs in estimates supplied by the Congressional Budget Office of the savings resulting from the medicaid and medicare provisions recommended by the Committee for inclusion in the Reconciliation bill. However, the Committee is in disagreement with an aspect of the estimate concerning costs resulting from Section 337. This section makes a technical change in the law to clarify that a particular State (Colorado) is not subject to a retroactive penalty for failure to meet certain utilization review requirements. This technical change reflects original Congressional intent, and is being made because of indications from the Department that this change is necessary to provide appropriate legal justification for waiving the penalty for Colorado. The amount in question is $8 million. The Department in all basic medicaid estimates has not assumed that this penalty would be applied. Yet the CBO has assumed a cost to this provision as though the original penalty was in fact subtracted from the medicaid base numbers on program costs. The Committee believes this represents double counting. Unless the base has been reduced to indicate that the penalty would be taken, no cost should be attributed to the provision.

Two additional points should be noted about the general estimates. First, the estimates indicate substantial medicare savings in addition to the medicaid savings which the Committee was directed to achieve. These medicare savings are also included in the cost estimates provided by CBO to the Ways and Means Committee. Second, the estimates also indicate certain increases in expenditures. This occurs because the Committee elected to include the full text of H.R. 4000 in its recommendations to the Budget Committee, since that legislation had been previously reported by the Committee. The Committee believes that all parts of the legislation are interrelated, and so both the savings provisions contained in H.R. 4000 and the other provisions of the bill were included. Adjustments have been made, however, to reduce the cost of the provisions which entail spending to the amount of spend-

ing for new and improved benefits assumed in the First Budget Resolution.

C. Report From the Congressional Budget Office

U.S. Congress,
Congressional Budget Office,
Washington, D.C., July 2, 1980.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for Subtitle A of Title III, Interstate and Foreign Commerce Committee Savings, of the Budget Reconciliation Recommendations.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

Alice M. Rivlin, *Director.*

Congressional Budget Office—Cost Estimate

1. Bill title: Subtitle A of Title III, Interstate and Foreign Commerce Savings, of the Budget Reconciliation Recommendations.

2. Bill status: As reported by the Committee on Interstate and Foreign Commerce on June 27, 1980.

3. Bill purpose: To bring the expenditures authorized by the House Interstate and Foreign Commerce Committee within the target for that Committee established by the First Concurrent Resolution on the Budget for fiscal year 1981.

4. Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985
H.R. 4000 (FUNCTION 550)					
Medicare:					
Budget authority	3	11	17	24	31
Estimated outlays:					
Sec. 306: Required activities of PSRO's	(1)	(1)	(1)	(1)	(1)
Sec. 309: Review of routine hospital admission services and preoperative hospital stays by PSRO's	−38	−65	−86	−102	−119
Sec. 310: Study of PSRO criteria	(1)	(1)	0	0	0
Sec. 311: Nonprofit hospital philanthropy	0	70	80	90	100
Sec. 313: Study of SNF dual participation	(1)	(1)	0	0	0
Sec. 320: Hospitals providing long-term care servces:					
Swing beds	2	10	17	19	20
Reimbursement for inappropriate hospital services	−48	−73	−83	−94	−107
Sec. 321: Coordinated audits	(1)	(1)	(1)	(1)	(1)
Sec. 324: Reimbursement for clinical laboratory services: Reimbursement limits	−14	−21	−23	−25	−27
Sec. 326: Second opinion demonstration projects; informed consent in certain demonstration projects	(1)	1	(1)	0	0
Sec. 328: Reimbursement for health maintenance organizations	1	5	25	35	40
Total medicare estimated outlays	−97	−73	−70	−77	−93
Total savings	−100	−159	−192	−221	−253
Total costs	3	86	122	144	160

BEST DOCUMENT AVAILABLE

BEST DOCUMENT AVAILABLE

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985
Medicaid (function 550):					
Required budget authority	−129.9	−39.1	43	59	77
Estimated outlays:					
Sec. 309: Review of routine hospital admission services and preoperative stays by PSRO's	−4	−6	−6	−7	−7
Sec. 311: Nonprofit hospital philanthropy	0	11	12	14	15
Sec. 320: Hospitals providing long-term care services:					
Swing beds	1	6	9	10	11
Reimbursement for inappropriate hospital services	−13	−20	−23	−26	−30
Sec. 321: Coordinated audits	−4	−5	−6	−6	−7
Sec. 322: Demonstration projects for training AFDC recipients as home health aides	1	−1	−9	−13	−18
Sec. 324: Reimbursement for clinical laboratory services:					
Reimbursement limits	−5	−7	−8	−8	−9
Competitive bidding	−7	−11	−9	0	0
Sec. 326: Second opinion demonstration projects; informed consent in certain demonstration projects	(1)	(1)	(1)	0	0
Sec. 331: Reimbursement for nurse-midwives	(1)	(1)	(1)	(1)	(1)
Sec. 332: Continuing eligibility despite cost-of-living increases	1	27	49	75	104
Sec. 333: Disposal of assets	−3	−7	−11	−16	−19
Sec. 334: Increased matching for the territories	18.1	31.9	35	38	40
Sec. 335: Funding for long-term care facility inspectors	9	10	11	0	0
Sec. 336: Funding for fraud control units	15	15	15	16	17
Sec. 337: Satisfactory utilization review	8	0	0	0	0
Sec. 341: Expedited review for certain disallowed claims	−147	−83	−16	−18	−20
Total, medicaid estimated outlays	−129.9	−39.1	43	59	77
Total savings	−183.0	−140.9	−62	−94	−110
Total costs	53.1	100.9	105	153	187
Other health (function 550):					
Authorization level	7	0	0	0	0
Estimated outlays: Sec. 326: Second opinion demonstration projects	1	4	1	1	0
AFDC (function 600):					
Required budget authority	(1)	−1	−5	−6	−7
Estimated outlays: Sec. 322: Demonstration projects for training AFDC recipients as home health aides	(1)	−1	−5	−6	−7
Totals for H.R. 4000:					
Budget authority/authorization level	−119.9	−29.1	55	77	101
Estimated outlays	−225.9	−109.1	−31	−23	−23
Total savings	−283.0	−300.0	−259	−321	−370
Total costs	57.1	190.9	228	298	347

[1] Estimated costs or savings less than $500,000.

D. Section-by-Section Analysis of Committee Recommendations

Section 301

The first section contains the short title, "Medicare and Medicaid Amendments of 1979."

Section 302. Expanded membership of professional standards review organizations

Section 302 of the bill amends section 1152(b)(1)(A) of the Social Security Act to provide for membership in a PSRO, at the option of the PSRO, of health care practitioners (other than doctors of medicine or osteopathy) engaged in the practice of their professions in the organization's area who hold independent hospital admitting privileges however, such practitioners may not make final determinations with respect to the professional conduct or services of doctors of medicine or osteopathy. (Doctors of medicine or osteopathy can be PSRO members under present law.)

Section 303. Registered nurse and dentist membership on statewide council advisory group

Section 303 of the bill amends section 1162(a)(1) of the Social Security Act to require the inclusion of at least one registered professional nurse and at least one doctor of dental surgery or dental medicine in the membership of an advisory group to a statewide Professional Standards Review Council.

Section 304. Nonphysician membership on National Professional Standards Review Council

Section 304(a) of the bill amends section 1163(a)(1) of the Social Security Act to provide that the membership of the National Professional Standards Review Council will include (in addition to its present membership) one doctor of dental surgery or dental medicine, one registered professional nurse, and one other health practitioner other than a doctor of medicine or osteopathy.

Section 304(b) of the bill amends section 1163(a)(2) of the Social Security Act to provide that the terms of no more than five members of the Council shall expire in any year.

Section 304(c) of the bill amends section 1163(a)(3) of the Social Security Act to provide that the Secretary shall periodically designate one of the physician members of the Council to serve as the Council's chairman.

Section 304(d) of the bill amends section 1163(d) of the Social Security Act to provide that physician members of the Council shall consist of physicians of recognized standard and distinction in the appraisal of medicine practices.

Section 304(e) of the bill makes a conforming amendment in section 1173 of the Social Security Act.

Section 304(f) provides that the amendment made by section 4 become effective 180 days after enactment of the bill.

Section 305. Efficiency in delegated review

Section 305 amends Section 1155(e) of the Social Security Act to provide that review may be delegated to a hospital by the PSRO if the hospital can demonstrate its capacity to review efficiently, as well as effectively and in timely fashion (as under current law).

Section 306. Required activities of professional standards review organizations

Section 306(a)(1) amends section 1154(b) of the Social Security Act to limit conditional PSRO required review responsibilities to hospital services (other than ancillary, ambulatory care, and long-term care services) and other duties and functions as the Secretary may require (pursuant to new Section 1154(f)(2) and (f)(4) as added by Section 306(a)(3) and with the organization is capable of performing. Section 306(a)(1) further provides that in order to be a qualified fully designated PSRO the Secretary must find that the organization is substantially carrying out these activities and functions in a satisfactory manner.

Section 306(a)(2) amends section 1154(c) of the Social Security Act to make a conforming change.

Section 306(a)(3) adds a new Section 1154(f) to the Social Security Act.

New Section 1154(f)(1) requires the Secretary to establish a program for the evaluation of the cost-effectiveness of review of particular health care services by PSRO's.

New Section 1154(f)(2) requires the program to be designed in a manner so that the Secretary will require particular PSRO's, chosen by a statistically valid method that will permit a valid evaluation of the cost-effectiveness of such review, to review particular health care services. This is in order to demonstrate the cost-effectiveness of requiring review of such services before such review is generally required.

New Section 1154(f)(3) requires the program to provide for the evaluation of cost-effectiveness of this review, particularly in comparison with areas in which such review was not required or performed.

New Section 1154(f)(4) provides that based upon such evaluation (or upon an evaluation of comparable statistical validity) and a finding that such review is cost-effective or yields other significant benefits, the Secretary shall specify those health care services which PSRO's (either generally or under such conditions and circumstances as the Secretary may specify) have the duty and the function of reviewing.

New Section 1154(f)(5) specifies that the program does not apply to health care services (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals.

Section 306(b) amends Section 1154(a) of the Social Security Act to provide that PSRO's are required to assume additional review responsibilities only to the extent and at the time specified by the Secretary under new Section 1154(f).

Section 306(c) strikes Section 1155(g) of the Social Security Act pertaining to review in shared health facilities and ambulatory care review.

Section 306(d) amends Section 1155 of the Social Security Act by adding a new subsection (h), which permits the Secretary to designate another qualified PSRO to conduct reviews of services for which a designated PSRO has not assumed review responsibilities.

Section 307. Response of professional standards review organizations to Freedom of Information Act requests

Section 307 provides that no PSRO designated (conditionally or otherwise) shall be required to make available any records pursuant to a request under the Freedom of Information Act until after the end of the 180 day period beginning on the date of entry of a final court order requiring such release.

Section 308. Consultation by professional standards review organizations with health care practitioners

Section 308(a) amends section 1155(a) of the Social Security Act by adding a new paragraph (8), which requires each Professional Standards Review Organization to consult (in a manner prescribed by the Secretary) with representatives of health care practitioners (other than physicians) and of institutional and noninstitutional providers of health care services, in relation to the Professional Standards Review Organization's responsibility for the review of the professional activities of such practitioners and providers.

Section 308(b) amends section 1162(e) of the Social Security Act to delete the requirement that the Professional Standards Review Or-

ganizations in a State which does not have a Statewide Professional Standard Review Council must be advised or assisted by an advisory group of not less than 7 nor more than 11 members who are representatives of health care practitioners, other than physicians.

Section 308(c) provides that the amendments made by section 308 become effective 180 days after the date of enactment.

Section 309. Review of routine hospital admission services and preoperative hospital stays by professional standards review organizations

Section 309(a) amends section 1155(a)(2) of the Social Security Act to authorize each Professional Standards Review Organization to determine, in advance, the medical necessity and appropriateness of any elective admission to a hospital or other health care facility (including admissions occurring on weekends) and any routine diagnostic services furnished in connection with such an admission. Section 9 further amends section 1155(a)(2) to permit the Secretary to direct each such organization to exercise this authority where he finds consistent with section 1154(f) that the determinations can be made on a timely basis and appropriate procedures will be applied to assure prompt notification of the determinations to providers, physicians, practitioners, and beneficiaries.

Section 310. Study of PSRO norms, standards, and criteria

Section 310 requires the Secretary to conduct, in consultation with the National Professional Standards Review Council, a nationwide study of the differences in medical criteria and length-of-stay norms utilized by Professional Standards Review Organizations in the various regions of the country and to report the findings and conclusions made with respect to the study to the Congress within one year of the date of enactment.

Section 311. Nonprofit hospital philanthropy

Section 311(a) adds a new section 1132, entitled "Encouragement of Nonprofit Hospital Philanthropy" to the Social Security Act.

New section 1132(a) states that it is the policy of the United States that philanthropic support for health care be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system.

New section 1132(b) states that for purposes of determining reasonable costs of services furnished by nonprofit hospitals under titles V, XVIII and XIX, unrestricted grants, gifts, and income from endowments shall not be deducted from any operating costs of such hospitals. In addition, the section provides that the following items shall not be deducted from any operating costs of such hospitals:

(1) A donor designated or restricted grant, gift, or income from an endowment, as these terms are defined for provider reimbursement under Medicare in 42 C.F.R. 405.423(b)(2);

(2) An unrestricted grant or gift, or income from such a grant or gift, which is not available for use as operating funds because of its designation by the hospital's governing board;

(3) A grant or similar payment which is made by a governmental entity and which is not available, under the terms of the grant or payment, for use as operating funds;

(4) The sale or mortgage of any real estate or other capital assets of the hospital which the hospital acquired through a gift or grant and which is not available for use as operating funds under the terms of the gift or grant or because of its designation by the hospital's governing board, except for recovery of the appropriate share of gains and losses realized from the disposal of depreciable assets; and

(5) A sinking fund which is (A) created by the hospital in order to meet a condition imposed by a third party for the third party's financing of a capital improvement of the hospital, and which fund is used exclusively to make payments to such third party for the financing of the capital improvement.

Section 311(b) provides that the new section 1132 of the Social Security Act shall apply to grants, gifts, and endowments made or established on or after September 1, 1981.

Section 312. Consultative services for skilled nursing facilities

Section 312 amends section 1864(a) of the Social Security Act to repeal the provisions authorizing Medicare reimbursement for consultative services furnished by State agencies to skilled nursing facilities.

Section 313. Study of need for dual participation of skilled nursing facilities

Section 313(a) requires the Secretary to conduct, after appropriate consultation, a study of the availability and need for skilled nursing facility services covered under Part A of title XVIII of the Social Security Act and under State plans approved under title XIX of such Act.

Section 313(b) requires the Secretary to complete this study and submit a report (including any recommendations for administrative or legislative changes), to the Committee on Finance of the Senate and to the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce of the House of Representatives within one year after enactment.

Section 314. Alternative to decertification of long-term-care facilities out of compliance with conditions of participation; look-behind authority

Section 314(a) amends section 1866 of the Social Security Act by adding a new subsection (f), which permits the Secretary to deny payment of services furnished to Medicare and Medicaid beneficiaries after a specified date by a skilled nursing facility out of compliance with the provider conditions of participation if the deficiencies do not immediately jeopardize the health and safety of patients. The section provides for similar action while decertification is underway if life and safety are immediately endangered. Subsection (f) further requires the Secretary to provide the facility the opportunity to correct its deficiencies, to provide a hearing for the facility before such denial of payments, and to provide notification to the facility and the public concerning such action.

Section 314(b)(1)(A) adds a new Section 1902(h) to the Social Security Act which authorizes similar State actions with respect to skilled nursing facilities and intermediate care facilities determined out of compliance under Medicaid.

Section 314(b)(1)(B) amends Section 1902(a)(33)(B) to authorize the Secretary to validate State determinations, and on that basis make independent and binding determinations, concerning the extent to which individual institutions and agencies meet the requirements for participation.

Section 314(b)(2) amends Section 1910 by adding a new subsection (c). New Section 1910(c)(1) provides that the Secretary may cancel approval of any skilled nursing or intermediate care facility under Medicaid at any time if he finds on the basis of a determination made by him that a facility fails to meet the appropriate requirements for participation under Medicaid, or if he finds grounds for termination of the provider agreement under Medicare. In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by Medicare and Medicaid shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur. The new Section 1910(c)(2) provides that any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies a such a facility for Medicaid, shall be entitled to a hearing by the Secretary and to judicial review.

Section 1910(c)(2) further provides that any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary. The agreement shall not be extended if the Secretary makes a written determination (specifying the reasons) that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.

Section 315. Life Safety Code requirements

Section 315 amends section 1861(j)(13) of the Social Security Act to delete the requirement that a skilled nursing facility must meet the 1973 edition of the Life Safety Code of the National Fire Protection Association, and to provide that such facility must meet applicable provisions of such edition of the Code as is specified in regulations.

Section 316. Criminal standards for certain medicare and medicaid-related crimes

Section 316 amends Sections 1877(b) and 1909(b) of the Social Security Act to clarify the provisions of current law that establish criminal penalties for solicitation or receipt of kickbacks, bribes, rebates or other remuneration in exchange for medicare and medicaid business. Section 316 specifies that such conduct does not constitute a felony unless it is knowing and willful.

Section 317. Exclusion of health care professionals convicted of medicare or medicaid-related crimes

Section 317(a) amends title XI of the Social Security Act by adding a new section 1127.

Subsection (a) of new section 1127 requires the Secretary to bar from participation in the programs established by titles XVIII and XIX of the Social Security Act any physician or other individual who has been convicted of a criminal offense related to either program.

Subsection (b) of new section 1127 specifies the manner in which the Secretary's determination under section 1127 will become effective.

Subsection (c) of new section 1127 specifies the right of any person adversely affected by a determination of the Secretary under section 1127(a) to a hearing on the record and to judicial review of the determination.

Section 317(b) amends section 1862(e) of the Social Security Act to prohibit payment under title XVIII to physicians or other individuals barred, under section 1127, from participation in the program.

Section 317(c) amends section 1902(a)(39) of the Social Security Act to prohibit payment under title XIX to physicians or other individuals barred under section 1127 from participation in the program.

Section 317(d) makes a conforming amendment to section 1902 of the Social Security Act by repealing subsection (g).

Section 318. Requirements concerning reporting of financial interest

Section 318 (a) amends section 1124(a)(3)(A)(ii) of the Social Security Act to provide that a disclosing entity is required to report only those individual interests in mortgages or other obligations equal to at least $25,000 or 5 percent of the entity's total assets.

Section 318 (b) amends section 1902(a)(35) to require the State plan under title XIX to provide that any entity receiving payments under such plan complies with the disclosure of ownership and related information requirements of section 1124.

Section 319. Withholding of Federal share of payments to medicaid providers to recover medicare overpayments

Section 319(a) amends the provisions of section 1902(a)(13) of the Social Security Act relating to State plan requirements for payment for inpatient hospital, skilled nursing facility, and intermediate care facility services to prohibit such payment where the State agency is subject to an order under new section 1913, added by subsection (d) of section 319 of the bill.

Section 319(b) and 319(c) make technical conforming amendments to section 1903, relating to payment to States.

Section 319(d) amends title XIX of the Social Security Act by adding a new section 1913, which permits the Secretary to withhold the Federal share of Medicaid payments to an institution (or person) that participates or has participated in (or has accepted assignment under) Medicare and from which the Secretary has been unable to recover (or determine the amount of) Medicare overpayments. New section 1913 further requires the Secretary to provide notice to the State agency and the provider of such action, and directs him to promulgate regulations to implement this section.

Section 320. Hospital providers of long-term-care services ("swing-beds")

Section 320(a)(1) amends title XVIII of the Social Security Act by adding a new section 1883 entitled "Hospital Providers of Extended Care Services."

New section 1882(a)(1) provides that any hospital (other than a hospital which has in effect a waiver of the 24-hour nursing service requirement imposed by section 1861(a)(5) of the Social Security Act) which has filed an agreement under section 1866 of the Social Security Act (relating to the charges a hospital may make for the medicare deductibles and coinsurance) may (subject to subsection (b) of this new section), enter into an agreement with the Secretary under which its inpatient facilities may be used to furnish services of the type which, if furnished by a skilled nursing facility, would constitute post-hospital extended care services.

New section 1882(a)(2) (A) and (B) provides that, notwithstanding any other provision of title XVIII of the Social Security Act, payment for services furnished under an agreement entered into under this new section shall be based on the reasonable cost of routine services (as determined under clause (ii) of paragraph (B)) and the reasonable cost of ancillary services (as determined under clause (iii) of paragraph (B)). Clause (ii) of paragraph (B) provides that the reasonable cost of routine services furnished during any calendar year is equal to the product of the number of patient days during the year for which the services were furnished and the average reasonable cost per patient day (such average being the average rate per patient day paid for routine services during the previous calendar year under title XIX of the Social Security Act to skilled nursing facilities located in the State in which the hospital is located and which have agreements under sec. 1902(a)(28) of the Social Security Act). Clause (iii) of paragraph (B) provides that the reasonable cost of ancillary services shall be determined in the same manner as for inpatient hospital services.

New section 1882(b) provides that the Secretary may not enter into an agreement under this section unless the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under sec. 1521 of the Public Health Service Act).

New section 1882(c) provides that an agreement with a hospital under this section shall, except as otherwise provided by the Secretary in regulations, be subject to termination on the same conditions and impose the same duties, responsibilities, conditions, and limitations as agreements entered into under section 1866 of the Social Security Act. A hospital whose agreement under this section has been terminated is not eligible to enter a new agreement under this section for at least 2 years from the termination date.

New section 1882(d) provides that payment may be made to a hospital under an agreement entered into under this section for extended care services only if payment would have been made for such services if they had been furnished by a skilled nursing facility; and individuals on whose behalf such payments are made shall be deemed, for purposes of title XVIII of the Social Security Act, to have received post-hospital extended care services.

New section 1882(e) provides that during the period a hospital has in effect an agreement under this section, the total reimbursement received for routine services from all classes of long-term care patients shall be subtracted from the hospital's total routine costs before calculations are made to determine medicare's reimbursement for routine hospital services.

New section 1882(f) requires a hospital which enters into an agreement with the Secretary under section 1883 to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital, which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility, are subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate.

New section 1882(g) requires the Secretary to prescribe an alternative method for determining the reasonable cost of post-hospital extended care services furnished in a distinct part of a hospital certified as a skilled nursing facility under section 1861(j) that is the same "swing-bed" method provided in new section 1882.

Section 320(a)(2) amends section 1861(v)(1) by adding a new subparagraph (G), relating to in patient services that would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility.

New subparagraph (G) requires payment for such services to be computed as provided in new section 1882(a), if the following conditions are met: (1) such services are furnished on the basis of a determination by a Professional Standards Review Organization (or other authorized review organization) that post-hospital extended care services are medically necessary and such services are not otherwise available; (2) such hospital has had, during the immediately preceding calendar year, an average daily occupancy rate of less than 80 percent; and (3) such hospital could be granted a certificate of need for the provision of long-term services from the designated State health planning and developing agency for the State in which the hospital is located. New subparagraph (G) further provides that where such payment is made, the individual who is furnished such services will be deemed, for purposes of title XVIII, to have received post-hospital extended care services. In addition, the Secretary is required to submit to the Congress, within 3 years after the date of enactment, a report evaluating the program established by the amendment made by section 320(a)(1) of the bill.

Section 320(b) of the bill amends title XIX of the Social Security Act by adding a new section 1914, entitled "Hospital Providers of Skilled Nursing and Intermediate Care Services." New section 1914 conforms medicaid reimbursement for skilled nursing facility services and intermediate care facility services furnished by a hospital (including a long-term care provided in a distinct part of the hospital) with an agreement under new section 1882 to the "swing-bed" payment provisions of that section.

Section 320(c) provides that the amendments made by the section become effective on the date on which final implementing regulations are first issued; and provides further that those regulations must be issued not later than the first day of the sixth calendar month following the month in which the bill is enacted.

Section 321. Coordinated audits under the Social Security Act

Section 321(a) of the bill amends title XI of the Social Security Act by adding at the end thereof a new section 1128 entitled "Coordi-

nated Audits." The new section 1128(a) provides that if any entity furnished services that are reimbursable on a cost-related basis under titles V or XIX, as well as under title XVIII of the Social Security Act, the Secretary shall require, as a condition of payment to any State under titles V or XIX with respect to administrative costs incurred in the performance of audits of that entity, that these audits be coordinated with audits performed for purposese of title XVIII of such act. The Secretary shall specify the method for apportioning the cost of coordinated audits among the programs established under these titles. Where a State has declined to participate in a common audit with respect to titles V or XIX, the Secretary shall reduce the payments otherwise due the State under such titles by an amount he estimates exceeds the amount that would have been apportioned to the State (for the expenses of the State incurred in the common audit) if it had participated in the common audit.

New Section 1128(b)(1) requires the Secretary to conduct one or more demonstration projects to test the feasibility of a single coordinated appeal process to resolve disputes arising from coordinated audits. New Section 1128(b)(2) provides that the Secretary may waive such requirements of titles V, XVIII and XIX as would prevent carrying out the project, require duplicative activity or otherwise create unnecessary burdens. New section 1128(b)(3) requires the Secretary to report to Congress no later than April 1, 1982 on the projects including reaction of entities involved, estimates of savings, and legislative recommendations deemed appropriate.

New Section 1128(b)(4) requires the Secretary to review the feasibility of establishing a single coordinated process for the collection of overpayments established by a coordinated audit and to report his findings and recommendations to the Congress by April 1, 1981.

Section 321(b)(1) of the bill amends Section 1902(a) of the Social Security Act by adding a new paragraph (41) which makes conforming amendments in title XIX of the Social Security Act with respect to the performance of common audits of entities also providing services under XVIII of the Social Security Act and the apportionment of the cost for the performance of such common audits.

Section 321(b)(2) of the bill provides that the new paragraph (41) shall apply to medical assistance provided under a State plan approved under title XIX of the Social Security Act, on or after the first day of the first calendar quarter beginning more than 30 days after the date of enactment of the bill except where State legislation is required. In this case the State is given until the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of the bill.

Section 321(c)(1) of the bill amends Section 505(a) of the Social Security Act by adding a new pargraph (15) which makes conforming amendments in title V of the Social Security Act with respect to the performance of common audits of entities also providing services under title XVIII of such act and the apportionment of the cost for the performance of such common audits.

Section 321(c)(2) of the bill provides that the new pargraph (15) shall apply to services provided, under a State plan approved under title V of the Social Security Act, on or after the first day of the first calendar quarter beginning more than 30 days after the date of enactment of the bill.

Section 321(d) of the bill requires the Secretary to report to the Congress, no later than July 1, 1980, on the actions he has taken to: (1) coordinate the conduct of institutional audits and inspections required under the programs funded under titles V, XVIII, or XIX of the Social Security Act; and (2) coordinate such audits and inspections with those conducted by other cost payers. The Secretary is to include in this report such legislative recommendations as he deems appropriate to assure maximum feasible coordination of such institutional audits and inspections.

Section 322. Demonstration projects relating to the training of AFDC recipients as home health aides

Section 322(a) permits the Secretary to enter into agreements with States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of eligible participants as homemakers or home health aides, who are to provide authorized services to elderly or disabled individuals, or other needy individuals.

Section 322(b) defines for purposes of this section the term "eligible participant" as an individual who has voluntarily applied for participation and who, at the time such individual enters the demonstration project, has been eligible for financial assistance under a State plan approved under Part A of title IV of the Social Security Act and has continuously received such financial assistance during the immediately preceding 90-day period and who, within such 90-day period, had not been employed as a homemaker or home health aide.

Section 322(c)(1) requires the Secretary to enter into agreements under section 322 with no more than 12 States and requires that priority be given to States which have demonstrated interest in providing such homemaker or home health aid services.

Section 322(c)(2) permits a State to apply to enter into an agreement under section 322 in such manner and at such time as the Secretary prescribe.

Section 322(c)(3) requires any State entering into an agreement with the Secretary under section 322 to:

(*a*) provide that the demonstration project be administered by a State health services agency designated for this purpose by the Governor;

(*b*) provide that the agency so designated must arrange for coordinating its activities under the agreement with activities of other State agencies maving related responsibilities;

(*c*) establish a formal training program, which meets such standards as the Secretary may establish, to assure the adequacy of such program to prepare eligible participants to provide part-time and intermittent services to individuals who are elderly, disabled, or otherwise in need of such services;

(*d*) provide for the full-time employment of those eligible participants who successfully complete the training program with one or more public agencies (or, by contract, with private bona fide nonprofit agencies) as homemakers or home health aides rendering authorized services under appropriate supervision at wage levels comparable to the prevailing wage levels in the area for similar work;

(*e*) provide that such services must be made available without regard to income of the individual requiring such services, but

that a reasonable fee will be charged for services provided to individuals who have income in excess of 200 percent of the needs standard in the State under the State plan approved under Part A of title IV of the Social Security Act for a household of the same size as the individual's household;

(*f*) provide for a system of continuing independent professional review by an appropriate panel to assure that services are provided only to individuals reasonably determined to be in need of such supportive services;

(*g*) provide for evaluation of the project and review of all agencies providing services under the project;

(*h*) submit periodic reports to the Secretary as he may require; and

(*i*) meet such other requirements as the Secretary may establish for the proper and efficient implementation of the project.

Section 322(c)(4) provides that the number of participants in any project must not exceed that number which the Secretary determines to be reasonable, based upon the capability of the agencies involved.

Section 322(c)(5) requires any contract with a private bona fide nonprofit agency entered into to provide a training program under the project must provide for reasonable reimbursement of such agencies for services.

Section 322(c)(6) specifies, for purposes of section 322, that a facility of the Veterans' Administration must, at the request of the Administrator of Veterans' Affairs, be considered to be a public agency. In the case of any such facility, of the costs determined under section 322 which are attributable to such facility, 90 percent must be paid by the State and 10 percent by the Veterans' Administration.

Section 322 (d)(1) defines authorized homemaker and home health aide services to include part-time or intermittent—

(*a*) personal care;

(*b*) assisting patients having limited mobility;

(*c*) feeding and diet assistance;

(*d*) home management, housekeeping, and shopping;

(*e*) health-oriented record keeping;

(*f*) family planning services; and

(*g*) simple procedures for identifying potential health problems.

Section 322(d)(2) specifies that such authorized services do not include any services performed in an institution, or any services more efficiently provided in an institution.

Section 322(e)(1) requires the Secretary to pay, under agreements entered into under section 322 with the State agency designated by the Governor, 90 percent of the reasonable cost incurred (less the Federal share of any related fees collected) by such State in carrying out the demonstration project.

Section 322(e)(2) limits the demonstration projects to a maximum duration of 4 years, plus an additional period of up to 6 months for planning and development, and up to 6 months for final evaluation and reporting and prohibits Federal funding for the employment of any eligible participant under the project after such participant has been employed for a period of 3 years.

Section 322(f) provides that for purposes of title IV of the Social Security Act, any eligible participant taking part in a training pro-

gram under such a project is to be participating in a work incentive program established by Part C of such title.

Section 322(g) continues the eligibility of eligible participants employed in the demonstration project for medical assistance under title XIX of the Social Security Act, and any eligibility for social and supportive services provided under Part A of title IV of such Act, for the first year (and such succeeding period as the State may specify) of such employment.

Section 322(h) requires the Secretary to submit annual reports to the Congress evaluating the demonstration projects carried out under section 322 and a final report to the Congress not less than 6 months after he has received the final reports from all States participating in such projects.

Section 322(i) authorizes the Secretary to waive such requirements, including formal solicitation and approval requirements, as will further expeditious and effective implementation of these provisions.

Section 323. Quality assurance programs for clinical laboratories

Section 323 amends section 1123(a) of the Social Security Act to extend until December 31, 1980 the program conducted by the Secretary to determine the proficiency of individuals who do not otherwise meet formal qualifications criteria to perform the duties of certain health care personnel.

Section 324. Reimbursement of clinical laboratories under medicare and medicaid

Section 324(a)(1) amends Section 1842 of the Social Security Act by adding a new subsection (h). The new subsection (h) establishes certain limits on reimbursement laboratory tests billed by physicians. New subsection h(1) provides that payment shall be the reasonable charge for the service (less the applicable deductible and coinsurance amounts) if the bill or request for payment indicates that the physician who submitted the bill or for whose services the request for payment was made personally performed or supervised the performance of the test or that another physician with whom the physician shares his practice personally performed or supervised the test. New subsection h(2) provides that the physician's bill or request for payment indicates the test was performed by a laboratory, identifies the laboratory and the amount charged, the payment (less applicable deductible and coinsurance amounts) shall be the lower of the laboratory's reasonable charge to Part B enrollees for the test or the amount the laboratory charged the physician. In addition, payment may include a nominal fee (where the physician bills for such service) to cover the physician's costs in handling the sample. New subsection h(3) provides that payment shall be the lowest charge at which the carrier estimates the test could have been secured by a physician from a laboratory serving the locality (less applicable deductible and coinsurance amounts) if the bill or request for payment: (A) does not indicate who performed the test, or (B) indicates that the test was performed by a laboratory but does not identify the laboratory or include the amount charged by the laboratory.

Section 324(a)(2) specifies that the amendments made by subsection 324(a)(1) shall apply to bills submitted and requests for payments

made on or after the date the Secretary of HHS prescribes in a notice in the Federal Register but no later than October 1, 1980.

Section 324(a)(3) requires the Secretary to report to the Congress within 24 months of the effective date specified in Section 324(a)(2) on: (A) the proportion of bills and requests for payments submitted (during the eighteen-month period beginning on such effective date) under title XVIII for laboratory tests which did not identify who performed the tests; (B) the proportion of bills and requests for payment submitted during such period for laboratory tests with respect to which the amount paid was less than the amount that would otherwise have been payable in the absence of the new Section 1842(h); (C) with respect to requests for payment which were submitted by patients, the average additional cost per laboratory test to patients resulting from reductions in payment that would otherwise have been made for such tests in the absence of new Section 1842(h), and (D) with respect to bills which were submitted by physicians, the average reduction in payments per laboratory test to physicians resulting from the application of new Section 1842(h).

Section 324(b)(1) amends section 1902(a) of the Social Security Act relating to State plan requirements for Medicaid by adding a new paragraph 42. The new paragraph 42 provides that if the State plan makes provision for payment to a physician for laboratory services which such physician (or any other physician with whom he shares his practice) did not personally perform or supervise, the plan must insure that payment for such laboratory services not exceed the payment authorized for such services by the new Section 1842(h).

Section 324(b)(2)(A) provides that the amendments made by Section 324(b)(1) shall (except where State legislation is required) apply to medical assistance provided under a State plan on and after the first calendar quarter that begins more than six months after the date of enactment. Section 324(b)(2)(B) provides that where the Secretary determines that State legislation is required in order for the plan to meet the additional requirements imposed by Section 324(b)(1), the State plan shall not be regarded as failing to comply with the requirements of Title XIX of the Social Security Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this bill.

Section 324(c)(1)(A) amends Section 1902(a)(23) of the Social Security Act pertaining to freedom of choice requirements under Medicaid by adding a new subparagraph (B). The new subparagraph (B) allows States to purchase laboratory services covered under their State plans through a competitive bidding process or otherwise for a three-year period beginning on the later of October 1, 1980, or on the date of enactment. Such purchase arrangements can be made if the Secretary has found that: (1) adequate service will be available under such arrangements; (2) such laboratory services will be provided only through laboratories which meet the health, safety and other requirements of Section 1861(e)(9) or paragraphs (10) and (11) of Section 1861(s) of the Social Security Act, and such additional requirements as the Secretary may require; (3) no more than 75 percent of the

laboratories' charges for such services are for services provided to individuals who are entitled to benefits under Medicaid or Medicare and (4) charges for services provided under such arrangements are made at the lowest rate charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such services) for comparable services by the provider of such services, or, if charged for on a unit price basis, such charges result in aggregate expenditures not in excess of expenditures that would be made if charges were at the lowest rate charged for comparable services by the provider of such services.

Section 324(c)(1)(B) requires the Secretary to evaluate the arrangements made for purchase of laboratory services under the new Section 1902(a)(23)(B) of the Act and transmit that evaluation to the Congress within 24 months of enactment together with recommendations as to whether such section should be extended or modified.

Section 324(c)(2) amends Section 1902(a)(9) by adding a new subparagraph (C). New subparagraph (C) provides that laboratory services must be provided by laboratories meeting requirements for participation under Medicare as specified in Section 1861(e)(9) or paragraphs (10) and (11) of Section 1861(s) of the Social Security Act.

Section 325. Reimbursement of physicians' services in teaching hospitals

Section 325(a)(1) amends Section 1861(b)(7) by providing that the term inpatient hospital services includes services rendered by a supervisory physician where the hospital has an approved teaching program if: (A) the hospital elects to receive any payment due on a reasonable cost basis for such services and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to Medicare patients.

Section 325(a)(2) amends Section 1832(a)(2)(B)(i)(II) of the Social Security Act to make a conforming change.

Section 325(b) provides that the amendments made by Section 325 (a) shall apply with respect to cost accounting periods beginning on or after October 1, 1978. Section 325(b) also provides that a hospital's election to receive reasonable cost reimbursement for supervisory physicians under the provisions of Section 1861(b)(7)(A) of the Social Security Act (as administered in accordance with Section 15 of Public Law 93-233) as of September 30, 1978, shall constitute such hospital's election under such section (as amended by this Act) on and after October 1, 1978, until the hospital provides otherwise.

Section 326. Demonstration projects for requiring second opinions for certain elective surgical procedures under medicare and medicaid; application of informed consent to certain demonstration projects

Section 326(a)(1) adds a new Section 1130 to the Social Security Act entitled "Demonstration Projects for Requiring Second Opinions for Certain Elective Surgical Procedures Under Medicare and Medicaid."

New Section 1130(a)(1) authorizes the Secretary to make grants to, and enter into contracts with, public and private non-profit entities (including professional standards review organizations and medical

Regulations (applicable to research, development, and related activities in which human subjects are involved).

Section 326(b)(1) amends Section 1861(q) of the Social Security Act to include consultation as to the necessity and appropriateness of elective surgical procedures within the definition of physicians services.

Section 326(b)(2) amends Section 1833(a)(1) of the Social Security Act by adding new paragraphs (F). New paragraph (F) provides that payment for a second or third opinion as to necessity and appropriateness of specified elective surgical procedures under a Medicare demonstration project shall be equal to 100 percent of the reasonable charge for such opinioin. In addition, the Part B deductible shall not be applicable with respect to such opinions.

Section 326(b)(3) amends Section 1842(b)(3)(B) of the Social Security Act to make a conforming change. The section further amends Section 1842(b) of such Act by adding a new paragraph (6). New paragraph (6) provides that payment for a second or third opinion under a Medicare demonstration project shall be on an assignment basis.

Section 326(b)(4) provides that the amendments made by Section 326 shall take effect with respect to opinions provided on or after the first day of the first month beginning after the date of the enactment of the bill.

Section 326(c)(1) amends Section 1903(a) of the Social Security Act by adding a new paragraph (7). New paragraph (7) provides for 90 percent Federal matching for the performance of a second or third opinion as to necessity and appropriateness of specified elective surgical procedures under a Medicaid demonstration project.

Section 326(c)(2) makes a conforming change in the Social Security Act.

Section 326(c)(3) provides that the amendments made by section 37(c) shall apply to calendar quarters beginning on or after October 1, 1980.

Section 326(d) provides that a demonstration project under new Section 1130 of the Social Security Act shall not apply to an individual unless the individual has provided a written and legally effective informed consent, described in section 46.103(c) of title 45, Code of Federal Regulations, to participate in the project. This section shall apply notwithstanding section 326(a)(2) of this bill (providing that second opinion demonstration projects shall not be construed to be subject to any of the requirements of 45 C.F.R. Part 46) and new Section 1130(d)(1) of the Social Security Act (prohibiting except under certain circumstances, payment for specified elective procedures covered under a second opinion demonstration project if a second opinion has not been obtained).

Section 327. Continued use of demonstration project reimbursement systems

Section 327(a) amends Section 1814(b) of the Social Security Act by adding a new paragraph (3). The new paragraph (3) provides for the continued use, in hospitals which have been reimbursed under such systems, of reimbursement systems, approved for use as a demonstra-

tion project under Section 402 of the Social Security Amendments of 1967, provided the following conditions are met:

(A) Some or all of the hospitals in the State have been reimbursed for Medicare services pursuant to such reimbursement systems.

(B) The rate of increase in such hospitals' costs per inpatient admission for Medicare beneficiaries was equal to or less than such increase with respect to all U.S. hospitals during the duration of the project.

(C) Either the State has legislative authority to operate such a system and it elects to continue the reimbursement system for such hospitals; or the system is operated through a voluntary agreement of hospitals and they elect to have such reimbursement to such hospitals continued.

The hospitals shall continue to be reimbursed under the demonstration project reimbursement system until the Secretary determines that:

(A) A third party payor reimburses such a hospital on another basis; or

(B) The rate of increase for the previous three year period in costs per inpatient admission for Medicare beneficiaries in such hospitals is greater than such rate of increase in all U.S. hospitals over such period.

Section 327(b) amends Section 1902(a)(13)(D) of the Social Security Act to provide that hospitals which are reimbursed for Medicare Part A services in accordance with the new Section 1814(b)(3) must be reimbursed for inpatient services according to the same system under Medicaid.

Section 328. Reimbursement for health maintenance organizations

Section 328(a) revises the provisions of Section 1876 of the Social Security Act, entitled "Payments to Health Maintenance Organizations."

Subsection (a) of revised Section 1876 requires the Secretary to determine annually a per capita payment rate for each class (based on factors such as age, sex, institutional status, disability status, and place of residence) of Medicare beneficiaries equal to 95 percent of the adjusted average per capita cost for that class. The term "adjusted average per capita cost" is defined as the average per capita amount that the Secretary estimates in advance would be payable in any contract year for covered services if the services were to be furnished by other than a health maintenance organization.

The Secretary is required to make advance monthly payments from the appropriate trust funds in accordance with the established rate to a health maintenance organization for Medicare enrollees.

Subsection (b) of revised Section 1876 defines, for Medicare purposes, the term "health maintenance organization" as a public or private organization, under the laws of any State which is either a qualified HMO (as defined in Section 1310(d) of the Public Health Service Act) or meets the following requirements:

(A) provides or otherwise makes available to enrolled participants health care services, including at least physicians' services, inpatient hospital services, laboratory, X-ray, emergency, and preventive services, and out of area coverage;

ture made by or an behalf of a health care facility that would be exempted from certificate of need review under Section 1527 of the Public Health Service Act.

Section 328(d)(2) amends Section 1124(a)(2)(A) of the Social Security Act to make a conforming change.

Section 328(e) provides that the amendments made by Section 24 (except subsections (c) and (d)) shall generally apply to services furnished on or after the first day of the thirteenth calendar month which begins after the date of enactment of the bill, or earlier (but not earlier than July 1, 1981) if a health maintenance organization so requests and the Secretary agrees. These amendments do not apply to beneficiaries who are enrolled with a health maintenance organization at the time it enters into a contract under revised Section 1876 unless they request otherwise or the Secretary, because of the administrative costs or other burdens involved, requires the amendments to be applied.

The amendments also do not apply (unless the organization requests otherwise) for five years following enactment in the case of a health maintenance organization which had a risk-sharing contract with the Secretary under the existing provisions of Section 1876 immediately before the date of enactment.

Section 328(f) of the bill requires the Secretary to conduct a study of the additional benefits selected by health maintenance organizations pursuant to Section 1876(i)(2) of the Social Security Act, as added by Section 24(a) of the bill. The Secretary is required to report to the Congress within 24 months of the date of the enactment of the bill with respect to the findings and conclusions made as a result of the study.

Section 328(g) requires the Secretary to conduct a study evaluating the extent of, and reasons for, the termination by Medicare beneficiaries of their membership in health maintenance organizations. The Secretary is required to submit an interim report to the Congress within two years of the date of the enactment of the bill, and a final report within five years of the date of enactment containing findings and conclusions made as a result of the study.

Section 331. Reimbursement under medicaid for services furnished by nurse-midwives

Section 331(a)(1) amends Section 1905(a) of the Social Security Act by adding a new paragraph 17. The new paragraph adds services furnished by a nurse-midwife to the list of Medicaid services. Such services are those which a nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not he is under the supervision of, or associated with, a physician or other health care provider.

Section 331(a)(2) amends Section 1905 by adding a new subsection (n). The new subsection (n) defines the term "nurse-midwife" as a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary, and performs services in the area of management of the care of mothers and babies (throughout the maternity cycle) which he is legally authorized to perform in the State in which he performs such services.

Section 331(b) amends Section 1902(a)(13) of the Social Security Act by adding nurse-midwife services to the list of mandatory Medicaid services and make other conforming changes.

Section 331(c)(1) provides that the amendments made by Section 28 shall (except where State legislation is required, be effective with respect to Medicaid payments for calendar quarters beginning more than one hundred and twenty days after the date of enactment of this bill. Section 331(c)(2) provides that where the Secretary determines that State legislation is required in order for the plan to meet the additional requirements, the State plan shall not be regarded as failing to comply with the requirement of Title XIX of the Social Security Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this bill.

Section 332. Continuing medicaid eligibility for certain individuals by diregarding certain involuntary increases in income

Section 332 amends Section 1902(a) of the Social Security Act by adding a new sentence. The new sentence requires States in determining the continuing eligibility of Medicaid recipients to exclude from the calculation of an individual's income any cost-of-living or price index increase or annual general increase in Social Security, Railroad Retirement, Veterans or Civil Service benefits, annuities, pensions or other compensation. The new sentence applies with respect to individuals determined eligible for Medicaid in a month after May 1980 who would otherwise become ineligible in a subsequent month because of such increase. Their eligibility will continue until the first month in which they otherwise become ineligible.

Section 333. Limitation on medicaid eligibility for individuals who dispose of resources

Section 333(a)(1) amends Section 1902(a)(17)(B) of the Social Security Act by providing that the new Section 1902(j) of the Act is an exception to the provision regarding determination of income eligibility for the medically needy.

Section 333(a)(2) adds a new Section 1902(j) to the Social Security Act.

The new Section 1902(j)(1) permits a State to defer Medicaid eligibility for a specified period (notwithstanding the other provisions of Title XIX of the Social Security Act except for the new Section 1902(j)(2) and 1902(j)(4)) if an individual disposed of his resources within a specified period. States may defer eligibility if within two years preceding application for Medicaid coverage an individual (or other person whose resources are considered in determining his eligibility) had disposed of resources with an uncompensated value of $6,000 or more (which if retained would have made him ineligible) in order to establish Medicaid eligibility. The section provides that any disposition of resources within the specified period may be presumed to be for such purpose unless the State is furnished convincing evidence that the transaction was for some other purpose. The section further provides that uncompensated value is the sum of: (1) the current market value of the individual's (or other person's) equity interest

sets a maximum on the Federal medical assistance percentage for the jurisdictions at 50 percent.

Section 334(c)(1) provides that the amendments made by subsection (a) shall apply to fiscal year 1980 and subsequent fiscal years.

Section 334(c)(2)(A) provides that, except as specified in (B), amendments made by Section 334(b) shall apply with respect to care and services provided, under a State Medical plan in a calendar quarter beginning after September 30, 1979.

Section 334(c)(2)(B) provides that each of the agencies administering or supervising the administration of the State Medicaid plan for Puero Rico, the Virgin Islands, Guam, or the Northern Mariana Islands may elect not to have the amendments made by subsection (b) apply to any care or services provided in its jurisdiction to an individual over a period of time beginning before October 1, 1979, and ending after October 1, 1979.

Section 335. Extensions of increased funding for long-term-care facility inspection under medicaid

Section 335(a) amends Section 249B of P.L. 92–603 (as amended by P.L. 93–368 and P.L. 95–83) to delete the termination date specified in that section for Section 1903(a)(4) of the Social Security Act.

Section 335(b) amends Section 1903(a)(4) of the Act to specify that 100 percent Federal matching for skilled nursing facility inspectors under Medicaid is available for calendar quarters ending prior to October 1, 1983. This is a three year extension over current law.

Section 335(c) provides that the amendment made by Section 335(b) shall apply to calendar quarters beginning on or after October 1, 1980.

Section 336. Extension of increased funding for State medicaid fraud control units

Section 336 amends Section 1903(a)(6) of the Social Security Act to provide that ninety percent Federal matching is available for State Medicaid fraud control units for three years (beginning with the first quarter such increased matching was available in the State). The section further provides that seventy-five percent Federal matching is available for State Medical fraud control units in subsequent calendar quarters.

Section 337. Change in calendar quarter for which satisfactory utilization review must be shown to recive waiver of medicaid reduction

Section 337 amends Section 1903(g)(3)(B) of the Social Security Act to provide that the Secretary shall waive application of penalties for unsatisfactory utilization review showings under Medicaid for any calendar quarter of 1977 if the Secretary determines a satisfactory showing was made in any calendar quarter of 1978. It modifies the current law which provides that if the State is in compliance for the calendar quarter ending December 31, 1977 the Secretary shall waive penalties for the first three quarters occurring in 1977.

Section 341(a) amends Section 1116 of the Social Security Act to add a new subsection (e) which provides that in the case of a disallowance under title XIX, the Secretary shall provide the State with 30 days notice of his intent to disallow certain expenditures before the final notice of the disallowance, and after the final notice has been

under title I, VI, X, XIV, XVI, XIX, XX, or part A of title IV, shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance.

(c)(1) In the case of a disallowance under subsection (d) with respect to a State under title XIX the Secretary shall not make such a disallowance unless the State has been provided, at least 30 days before the date the final notice if such disallowance is provided to the State a preliminary notice of the Secretary's intent to make such a disallowance. After the Secretary provides a State such a final notice of disallowance and pending any reconsideration of such disallowance, the Secretary shall offset, from any subsequent payments made to the State under title XIX, an amount equal to the amount of the disallowance.

(2) If in the reconsideration (or appeal of a reconsideration) of such a disallowance, it is determined that the Secretary's disallowance (and offsetting) of an amount was incorrect, the Secretary shall pay to the State, in addition to the amount of such disallowance incorrectly taken, interest on such amount disallowed for the period beginning on the date such amount was offset from payment to the State and ending on the date it was paid to the State at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during such period.

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LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

SEC. 1122. (a) * * *

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(j) A capital expenditure made by or on behalf of a health care facility shall not be subject to review pursuant to this section if the obligation of the capital expenditure by the facility would not be required to be reviewed under section 1527 of the Public Health Service Act.

PROGRAM FOR DETERMINING QUALIFICATIONS FOR CERTAIN HEALTH CARE PERSONNEL

SEC. 1123. (a) The Secretary, in carrying out his functions relating to the qualifications for health care personnel under title XVIII, shall develop (in consultation with appropriate professional health organizations and State health and licensure agencies) and conduct (in conjunction with State health and licensure agencies) until December 31, [1977,] *1980*, a program designed to determine the proficiency of individuals (who do not otherwise meet the formal educational, professional membership, or other specific criteria established for determining the qualifications of practical nurses, therapists, laboratory technicians, and technologists, and sytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists) to perform the duties and functions of practical nurses, therapists, laboratory technicians, technologists, and cytotecholobists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists. Such program shall include (but not

be limited to) the employment of procedures for the formal testing of the proficiency of individuals. In the conduct of such program, no individual who otherwise meets the proficiency requirements for any health care specialty shall be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements.

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DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

SEC. 1124. (a)(1) The Secretary shall by regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

(A) as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by titles V, XVIII, XIX, and XX, or

(B) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under titles V, XVIII, XIX, and XX,

supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity or in any subcontractor (as defined by the Secretary in regulations) in which the entity directly or indirectly has a 5 per centum or more ownership interest.

(2) As used in this section, the term "disclosing entity" means an entity which is—

(A) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, a renal disease facility, or a health maintenance organization [(as defined in section 1301(a) of the Public Health Service Act)];

(B) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established pursuant to title V or under a State plan approved under title XIX;

(C) a carrier or other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of title XVIII, or both, or for purposes of a State plan approved under title XIX) pursuant to (i) an agreement under section 1816, (ii) a contract under section 1842, or (iii) an agreement with a single State agency administering or supervising the administration of a State plan approved under title XIX; or

(D) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health related services with respect to which payment may be claimed by the entity under a State plan or program approved under title XX.

(3) As used in this section, the term "person with an ownership or control interest" means, with respect to an entity, a person who—

(A) (i) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or

[(ii) is the owner (in whole or in part) of an interest of 5 per centum or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof; or]

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds $25,000 or 5 per centum of the total property and assets of the entity; or

(B) is an officer or director of the entity, if the entity is organized as a corporation; or

(C) is a partner in the entity, if the entity is organized as a partnership.

EXCLUSION OF CERTAIN INDIVIDUALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

SEC. 1127. (a) Whenever the Secretary determines that a physician or other individual has been convicted (on or after October 25, 1977, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such individual's participation in the delivery of medical care or services under title XVIII or title XIX, the Secretary—

(1) shall bar from participation in the program under title XVIII, for such period as he may deem appropriate, each such individual otherwise eligible to participate in such program;

(2) (A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX, of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) require each such agency to bar such individual from participation in such program for such period as he shall specify, which in the case of an individual specified in paragraph (1) shall be the period established pursuant to paragraph (1);

(B) may waive the requirement under subparagraph (A) to bar an individual from participation in a State plan program under title XIX, where he receives and approves a request for such a waiver with respect to that individual from the State agency administering or supervising the administration of such plan; and

(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such individual of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health, Education, and Welfare fully and currently informed with respect to any actions taken in response to such request.

(b) A determination made by the Secretary under this section shall be effective at such time and upon such reasonable notice to the public

and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services furnished under title XVIII, such determination shall be effective in the manner provided in paragraphs (3) and (4) of section 1866(b) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(c) Any person who is the subject of an adverse determination made by the Secretary under subsection (a) shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205 (b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

COORDINATED AUDITS

SEC. 1128. (a) If an entity provides services reimbursable on a cost-related basis under title V or XIX, as well as services reimbursable on such a basis under title XVIII, the Secretary shall require, as a condition for payment to any State under title V or XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of title XVIII. The Secretary shall specify by regulation such methods as he finds feasible and equitable for the apportionment of the cost of coordinated audits between the program established under title V or XIX and the program established under title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to title V or XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be in excess of the amount that would have been apportioned to the State under the title (for the expenses of the State incurred in the common audit) if it had participated in the common audit.

(b)(1) In the case of entities which have audits coordinated under subsection (a), the Secretary shall establish one or more projects to demonstrate the feasibility of creating a single coordinated appeal hearing to adjudicate those administrative cost items which are determined under such a coordinated audit and which such entities dispute and appeal.

(2) In the case of a demonstration project under this subsection, the Secretary may waive such requirements of title V, XVIII, or XIX as would prevent carrying out the project or would require duplicative activity or otherwise create unnecessary administrative burdens in carrying out the project.

(3) The Secretary shall report to Congress not later than April 1, 1982, on demonstration projects conducted under this subsection, including the reaction of the entities involved and estimates of any savings effected through reduction of duplication of appeal hearings, and

shall include in such report recommendations for such legislation as the Secreary deems appropriate to insure the maximum feasible coordination of such appeal hearings.

(4) The Secretary shall also provide for the review of the feasibility of establishing a single coordinated process for the collection of overpayments established in a coordinated audit under subsection (a). The Secretary shall report to Congress not later than April 1, 1981, on such review and on such recommendations for changes in legislation as the Secretary deems appropriate.

DEMONSTRATION PROJECTS FOR REQUIRING SECOND OPINIONS FOR CERTAIN ELECTIVE SURGICAL PROCEDURES UNDER MEDICARE AND MEDICAID

SEC. 1129. (a)(1) The Secretary is authorized to make grants to, and enter into contracts with, public and private no-profit entities, including professional standards review organizations designated (conditionally or otherwise) under part B of this title and medical societies, for the conduct of demonstration projects for the purpose of determining the cost-effectivenes sand appropriateness of requiring that a second opinion with respect to specified elective surgical procedures (defined in subsection (f)(1)) be provided before payment may be made under title XVIII or under a State plan approved under title XIX with respect to the performance of the procedure.

(2) To the extent feasible, the Secretary shall provide under this section for—

(A) demonstration projects applicable to all specified elective surgical procedures proposed to be furnished to individuals entitled to hospital insurance benefits under part A, and enrolled under the supplementary medical insurance program under part B, of title XVIII of this Act, and

(B) demonstration projects applicable to all specified elective surgical procedures proposed to be furnished to individuals eligible for medical assistance under State plans approved under title XIX of this Act.

(3) The Secretary shall provide, to the extent feasible—

(A) for at least seven demonstration projects under this section,

(B) that the number of such projects conducted be equally divided between projects described in paragraph 2(A) and projects described in paragraph (2)(B), and

(C) for the conduct of such projects in a variety of geographic settings and covering a variety of sizes of populations, in order to determine the relative effectiveness of requiring second opinions in different areas of the country and under programs of different sizes.

(b)(1) No grant may be made or contract entered into under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary may provide.

(2) The amount of any grant or contract under this section shall be determined by the Secretary.

(3) Grants and payments under contracts made for demonstration projects and related administrative expenses (including expenses for analysis of data) described—

(iii) *prostatectomy,*
(iv) *cataract surgery,*
(v) *hemorrhoidectomy, and*
(vi) *excision of varicose veins; and*

(B) *in the case of a demonstration project applicable to State plans approved under title XIX of this Act—*

(i) *hysterectomy,*
(ii) *menisectomy,*
(iii) *submucous resection,*
(iv) *hemorrhoidectomy,*
(v) *excision of varicose veins, and*
(vi) *tonsillectomy and adenoidectomy,*

if such procedures are medically necessary to treat other than an emergency medical condition. In addition, such term includes such other elective surgical procedures as the Secretary, in his discretion, determines to be appropriate.

(2) *The term "qualified physician" means, with respect to an opinion on a special elective surgical procedure for treatment of a medical condition of a particular patient, a physician who—*

(A) *is a board-eligible or certified specialist with respect to the procedure or with respect to treatment of the medical condition or who possesses such other qualifications with respect to such procedure or treatment as the Secretary may specify;*

(B) *agrees not to perform the surgical procedure for which the opinion is sought (except under emergency conditions); and*

(C) *is not affiliated with a physician who provided a previous opinion with respect to such treatment of such patient.*

* * * * * * *

ENCOURAGEMENT OF NONPROFIT HOSPITAL PHILANTHROPY

SEC. 1134. (a) *It is the policy of the United States that philanthropic support for health care be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system.*

(b) *For purposes of determining under titles, V, XVIII, and XIX the reasonable costs of services furnished by nonprofit hospitals, unrestricted grants, gifts, and income from endowments shall not be deducted from any operating costs of such hospitals, and, in addition, the following items shall not be deducted from any operating costs of such hospitals:*

(1) *A donor designated or restricted grant, gift, or income from an endowment, as defined in section 405.423(b)(2) of title 42 of the Code of Federal Regulations.*

(2) *An unrestricted grant or gift, or income from such a grant or gift, which is not available for use as operating funds because of its designation by the hospital's governing board.*

(3) *A grant or similar payment which is made by a governmental entity and which is not available, under the terms of the grant or payment, for use as operating funds.*

(4) The sale or mortgage of any real estate or other capital assets of the hospital which the hospital acquired through a gift or grant and which is not available for use as operating funds under the terms of the gift or grant or because of its designation by the hospital's governing board, except for recovery of the appropriate share of gains and losses realized from the disposal of depreciable assets.

(5) A sinking fund which is (A) created by the hospital in order to meet a condition imposed by a third party for the third party's financing of a capital improvement of the hospital, and which fund is used exclusively to make payments to such third party for the financing of the capital improvement.

PART B—PROFESSIONAL STANDARDS REVIEW

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DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1152. (a) * * *

(b) For purposes of subsection (a), the term "qualified organizations" means—

(1) when used in connection with any area—

(A) an organization (i) which is a nonprofit professional association (or a component organization thereof), (ii) which is composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area, *and, if the organization so elects, of other health care practitioners engaged in the practice of their professions in such area who hold independent hospital admitting privileges,* (iii) the membership of which includes a substantial proportion of all such physicians in such area, (iv) which is organized in a manner which makes available professional competence to review health care services of the types and kinds with respect to which Professional Standards Review Organizations have review responsibilities under this part, (v) the membership of which is voluntary and open to all doctors of medicine or osteopathy licensed to engage in the practice of medicine or surgery in such area without requirement of membership in or payment of dues to any organized medical society or association, and (vi) which does not *(except as otherwise provided under section 1155(c))* restrict the eligibility of any member for service as an officer of the professional Standards Review Organization or eligibility for and assignment to duties of such Professional Standards Review Organization, or, subject to subsection (c)(1),

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TRIAL PERIOD FOR PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1154. (a) * * *

(b) During any such trial period (which may not exceed 48 months except as provided in subsection (c), the Secretary may require a

Professional Standards Review Organization to perform, in addition to review of health care services [provided by or in institutions, only such of the duties and functions required under this part of Professional Standards Review Organization as he determines such organizations to be capable of performing] (*other than ancillary, ambulatory care, and long-term care services*) *provided by or in hospitals, only such of the duties and functions as he requires the organization to perform under subsection (f)(2) or subsection (f)(4) and which the organization is capable of performing.* The number and type of such duties shall, during the trial period, be progressively increased as the organization becomes capable of added responsibility so that, by the end of such period, such organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner, the activities and functions required of [Professional Standards Review Organizations under this part with respect to the review of health care services provided by or in institutions (including ancillary services) and, in addition, review of such other health care services as the Secretary may require] *that Professional Standards Review Organization under this part.* Any of such duties and functions not performed by such organization during such period shall be performed in the manner and to the extent otherwise provided for under law.

"(c) If the Secretary finds that an organization designated under subsection (a) has been unable to perform satisfactorily all of the duties and functions required under this part *of that organization* for reasons beyond the organization's control, he may extend such organization's trial period for an additional period not exceeding twenty-four months.

* * * * * * *

(f)(1) The Secretary shall establish a program (hereinafter in this subsection referred to as the 'program') for the evaluation of the cost-effectiveness of review of particular health care services by Professional Standards Review Organizations.

(2) In order to demonstrate the cost-effectiveness of requiring review of particular health care services before such review is generally required, the program shall be designed in a manner so that the Secretary will require particular Professional Standards Review Organizations, chosen by a statistically valid method that will permit a valid evaluation of the cost-effectiveness of such review, to review particular health care services.

(3) The program shall provide for the evaluation of cost-effectiveness of the review of particular health care services under the program, particularly in comparison with areas in which such review was not required or performed.

(4) Based upon such evaluation, or upon an evaluation of comparable statistical validity, and a finding that review of particular health care services is cost-effective or yields other significant benefits, the Secretary shall specify such particular health care services which Professional Standards Review Organizations (either generally or under such conditions and circumstances as the Secretary may specify) have the duty and function of reviewing under this part.

(5) For purposes of this subsection the term 'particular health care services' does not include health care services (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals.

DUTIES AND FUNCTIONS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1155. (a)(1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall be the duty and function of each Professional Standards Review Organization for any area to assume, [at the earliest date practicable] *to the extent and at the time specified by the Secretary under section 1154(f);* responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services (except as provided in paragraph (7)) and items for which payment may be made (in whole or in part) under this Act for the purpose of determining whether—

(A) such services and items are or were medically necessary;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type.

[(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

[(A) any elective admission to a hospital, or other health care facility, or

[(B) any other health care service which will consist of extended or costly courses of treatment,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in clauses (A) and (C) of paragraph (1).]

(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

(A) any elective admission to a hospital or other health care facility (including admissions occurring on weekends), and

(B) any routine diagnostic services furnished in connection with such an admission,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in subparagraphs (A) and (C) of paragraph (1). Each such Organization may be directed by the Secretary to exercise such authority where the Secretary finds (consistent with section 1154(f)) that such determinations can be made on a timely basis by the Organization and appropriate procedures will be applied to assure prompt notification of such determinations to providers, physicians, practitioners, and

persons on whose behalf payment may be made under this Act for services and items.

* * * * * * *

(7)(A) Except as provided in subparagraph (B), a Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities (as defined in section 1905(c)) and in public institutions for the mentally retarded (described in section 1905(a)(1) only, *consistent with section 1154(f)*, if (i) the Secretary finds, on the basis of such documentation as he may require from the State, that the single State agency which administers or supervises the administration of the State plan approved under title XIX for that State is not performing effective review of the quality and necessity of health care services provided in such facilities and institutions, or (ii) the State requests such organization to assume such responsibility.

(B) A Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities in the State that are also skilled nursing facilities (as defined in section 1861(j)), to the extent (*consistent with section 1154(f)*) that the Secretary finds that the performance of such function by the single State agency (described in subparagraph (A)) for that State is inefficient.

(8) *Each Professional Standards Review Organization shall consult (with such frequency and in such manner as may be prescribed by the Secretary) with representatives of health care practitioners (other than physicians described in section 1861(r)(1)) and of institutional and noninstitutional providers of health care services, in relation to the Professional Standards Review Organization's responsibility for the review under paragraph (1) of the professional activities of such practitioners and providers.*

(e)(1) Each Professional Standards Review Organization shall utilize the services of, and accept the findings of, the review committees of a hospital (including any skilled nursing facility, as defined in section 1861(j), or intermediate care facility, as defined in section 1905(c), which is also a part of such hospital) or other operating health care facility or organization (other than such a skilled nursing facility or intermediate care facility which is not a part of a hospital) located in the area served by such organization, but only when and only to the extent and only for such time that such committees in such hospital or other operating health care facility or organization have demonstrated to the satisfaction of such organization their capacity [effectively and in timely fashion] *effectively, efficiently, and in timely fashion* to review activities in such hospital or other operating health care facility or organization (including the medical necessity of admissions, types and extent of services ordered, and lengths of stay) so as to aid in accomplishing the purposes and responsibilities described in subsection (a)(1), except where the Secretary disapproves, for good cause, such acceptance.

(2) The Secretary may prescribe regulations to carry out the provisions of this subsection.

[(g)(1) Where a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) requests review responsibility with respect to services furnished in shared health facilities, the Secretary must give priority to such request, with the highest priority being assigned to requests from organizations located in areas with substantial numbers of shared health facilities.

[(2) The Secretary shall require any Professional Standards Review Organization which is capable of exercising review responsibility with respect to ambulatory care services to perform review responsibility with respect to such services on and after a date not earlier than the date the organization is designated as a Professional Standards Review Organization (other than under section 1154) and not later than two years after the date the organization has been so designated, but any such designated Professional Standards Review Organization may be approved to perform such review responsibility at any earlier time if such organization applies for, and is found capable of exercising such responsibility.]

(h) If the Secretary has designated an organization (other than under section 1154) as a Professional Standards Review Organization, but that organization has not assumed responsibility for the review of particular activities in its area included in subsection (a)(1), the Secretary may designate another qualified Professional Standards Review Organization (in reasonable proximity to the providers and practitioners whose services are to be reviewed) to assume the responsibility for the review of some or all of those particular activities.

STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCIL; ADVISORY GROUPS TO SUCH COUNCILS

SEC. 1162. (a) * * *

* * * * * * *

(e)(1) The Statewide Professional Standards Review Council for any State [(or in a State which does not have such Council the Professional Standards Review Organizations in such State which have agreements with the Secretary)] shall be advised and assisted in carrying out its functions by an advisory group (of not less than seven nor more than eleven members) which shall be made up of representatives (*including at least one registered professional nurse and at least one doctor of dental surgery or of dental medicine*) of health care practitioners (other than physicians) and hospitals and other health care facilities which provide within the State health care services for which payment (in whole or in part) may be made under any program established by or pursuant to this Act.

(2) The Secretary shall by regulations provide the manner in which members of such advisory group shall be selected by the Statewide Professional Standards Review Council [(or Professional Standards Review Organizations in States without such Councils)].

* * * * * * *

NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

SEC. 1163. (a)(1) There shall be established a National Professional Standards Review Council (hereinafter in this section referred to as

the "Council") which shall consist of eleven physicians, *one doctor of dental surgery or of dental medicine, one registered professional nurse, and one other health practitioner (other than a physician as defined in section 1861(r)(1))*, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

(2) Members of the Council shall be appointed for a term of three years, except that the Secretary may provide, in the case of any terms scheduled to expire after January 1, 1978, for such shorter terms as will ensure that (on a continuing basis) the terms of no more than [four] *five* members expire in any year. Members of the Council shall be eligible for reappointment.

(3) The Secretary shall from time to time designate one of the *physician* members of the Council to serve as Chairman thereof.

(b) [Members] *Physician members* of the Council shall consist of physicians of recognized standing and distinction in the appraisal of medical practice. A majority of such members shall be physicans who have been recommended by the Secretary to serve on the Council by national organizations recognized by the Secretary as representing practicing physicians. The membership of the Council shall include physicians who have been recommended for membership on the Council by consumer groups and other health care interests.

* * * * * * *

MEDICAL OFFICERS IN AMERICAN SAMOA, THE NORTHERN MARIANA ISLANDS, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS TO BE INCLUDED IN THE PROFESSIONAL STANDARDS REVIEW PROGRAM

SEC. 1173. For purposes of applying this part [(except sections 1155(c) and 1163)] (*except section 1155(c)*) to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

DESCRIPTION OF PROGRAM

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CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

REQUIREMENT OF REQUESTS AND CERTIFICATIONS

SEC. 1814. (a) * * *

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AMOUNT PAID TO PROVIDERS

(b)(1) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be—

(1) *except as provided in paragraph (3)*, the lesser of (A) the reasonable cost of such services, as determined under section 1861 (v) and as further limited by section 1881(b)(2)(B), or (B) the customary charges with respect to such services; or

(2) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services[.]; *or*

(3) if some or all of the hospitals in a State have been reimbursed for services (for which payment may be made under this part) pursuant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967 or section 222(a) of the Social Security Amendments of 1972, if the rate of increase in such hospitals in their costs per hospital inpatient admission of individuals entitled to benefits under this part over the duration of such project was equal to or less than such rate of increase for admission of such individuals with respect to all hospitals in the United States during such period, and if either the State has legislative authority to operate such system and the State elects to have reimbursement to such hospitals made in accordance with this paragraph or the system is operated through a voluntary agreement of hospitals and such hospitals elect to have reimbursement to those hospitals made in accordance with this paragraph, then such hospitals shall continue to be reimbursed under such system until the Secretary determines that—

(A) a third-party payor reimburses such a hospital on a basis other than under such system, or

(B) the rate of increase for the previous three-year period in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part is greater than such rate of increase for admissions of such individuals with respect to all hospitals in the United States for such period.

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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SCOPE OF BENEFITS

SEC. 1832. (a) The benefits to an individual by the insurance program established by this part shall consist of—

(1) * * *

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services for up to 100 visits during a calendar year;

(B) medical and other health services furnished by a provider of services or by others under arrangements with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, or

(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital) [, unless either clause (A) or (B) of paragraph (7) of such section is met] *where the conditions specified in paragraph (7) of such section are met*, and

(ii) services for which payment may be made pursuant to section 1835(b)(2); and

(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies; and

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1932(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology, the amounts paid shall be equal to 100 percent of the reasonable charges for such services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to diagnostic tests performed in a

laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (g) of this section), [and] (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, *and (F) with respect to a second or third opinion as to necessity and appropriateness of specified elective surgical procedures in the case of a demonstration project described in section 1129 (f)(1)(A), the amounts paid shall be equal to 100 percent of the reasonable charge for such opinion, and*

* * * * * * *

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $60; except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year and applied toward such individual's deductible under this section for such preceding year, [and] (2) such total amount shall not include expenses incurred for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology, *and (3) such total amount shall not include expenses incurred for a second or third opinion described in subsection (a)(1)(F) for an elective surgical procedure.* The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

* * * * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

(b)(1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided *in paragraph (6) of this subsection or* in section 1870(f)) be made—

(i) * * *

* * * * * * *

(5) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

(6) No such contract shall provide for payment for a second or third opinion described in section 1833(a)(1)(F) on a basis other than that described in clause (ii) of paragraph (3)(B).

* * * * * * *

(h) If a physician's bill or request for payment for a physician's services includes a charge to a patient for a laboratory test for which payment may be made under this part, the amount payable with respect to the test shall be determined as follows:

(1) If the bill or request for payment indicates that the physician who submitted the bill or for whose services the request for payment was made personally performed or supervised the performance of the test or that another physician with whom the physician shares his practice personally performed or supervised the test, the payment shall be the reasonable charge for the test (less the applicable deductible and coinsurance amounts).

(2) If the bill or request for payment indicates that the test was performed by a laboratory, identifies the laboratory, and indicates the amount the laboratory charged the physician who submitted the bill or for whose services the request for payment was made, payment for the test shall be the lower of—

(A) the laboratory's reasonable charge to individuals enrolled under this part for the test, or

(B) the amount the laboratory charged the physician for the test,

plus a nominal fee (where the physician bills for such a service) to cover the physician's costs in collecting and handling the sample on which the test was performed (less the applicable deductible and coinsurance amounts).

(3) If the bill or request for payment (A) does not indicate who performed the test, or (B) indicates that the test was performed by a laboratory but does not identify the laboratory or include the amount charged by the laboratory, payment shall be the lowest charged at which the carrier estimates the test could have been secured by a physician from a laboratory serving the locality (less the applicable deductible and coinsurance amounts).

* * * * * * *

PART C—MISCELLANEOUS PROVISIONS

DEFINITION OF SERVICE, INSTITUTIONS, ETC.

Sec. 1861. For purposes of this title—

Spell of Illness

(a) * * *

Inpatient Hospital Services

(b) The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) * * *

* * * * * * *

[(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), unless (A) such inpatient is a private patient (as defined in regulations), or (B) the hos-

pital establishes that during the two-year period ending December 31, 1967, and each year thereafter all inpatients have been regularly billed by the hospital for services rendered by physicians and reasonable efforts have been made to collect in full from all patients and payment of reasonable charges (including applicable deductibles and coinsurance) has been regularly collected in full or insubstantial part from at least 50 percent of all inpatients.]

(7) a physician where the hospital has a teaching program approved as specific in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.

Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) * * *

* * * * * * *

(13) meets such provisions of [the Life Safety Code of the National Fire Protection Association (23rd edition, 1973) as are applicable to nursing homes; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients] *such edition (as specified by the Secretary in regulations) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes;* except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities;

* * * * * * *

Physicians' Services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation (*including consultation as to the necessity and appropriateness of elective surgical procedures*), and home, office, and institutional calls (but not including services described in subsection (b)(6)).

* * * * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

* * * * * * *

(E) rural health clinic services; [and]

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies, *and*

(G) services furnished pursuant to a contract under section 1876 to a member of a health maintenance organization by a nurse practitioner and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

* * * * * * *

Reasonable Cost

(v)(1) (A) * * *

* * * * * * *

(G) Where a hospital furnishes inpatient services that would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility on the basis of a determination made by a Professional Standards Review Organization (or, in the absence of such a qualified organization, by such organization or agency with review responsibility as is otherwise provided for under this title) that (i) post-hospital extended care services are medically necessary; and (ii) that such services are not otherwise available (as determined in accordance with criteria established by the Secretary) at the time the determination is made that post-hospital extended care services rather than inpatient hospital services are medically necessary (and for such period as the circumstances described in clauses (i) and (ii) continue to apply); and where the Secretary finds that (I) such hospital has had, during the immediately preceding calendar year, an average daily occupancy rate of less than 80 percent, and (II) could be granted a certificate of need for the provision of long-term care services from the designated State health planning and development agency for the State in which the hospital is located, the reasonable cost of such services for such hospital shall be computed as provided for in section 1882(a). Where payment is made in accordance with the preceding sentence, the individual who is furnished such services will be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

* * * * * * *

Rural Health Clinic Services

(aa)(1) * * *

(2) The term "rural health clinic" means a facility which—

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of

health services) with one or more physicians (as defined in subsection (r)(1) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians or physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services;

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has appropriate procedures for review of utilization of clinic services to the extent that the Secretary determines to be necessary and feasible; and

(J) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and that is designated by the Secretary either (I) as an area with a shortage of personal health services under section 1302(7) of the Public Health Service Act or (II) as a health manpower shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which

such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistance or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause.

Physician Assistant and Nurse Practitioner

[(3)] (*bb*) The term "physician assistant" and the term "nurse practitioner" mean[, for the purposes of paragraphs (1) and (2),] a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

* * * * * * *

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) * * *

* * * * * * *

[(e)(1) Whenever the Secretary determines that a physician or other individual practitioner has been convicted (on or after the date of the enactment of this subsection, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such physician's or practitioner's involvement in the programs under this title or the program under title XIX, the Secretary shall suspend such pyhsician or practitioner from participation in the program under this title for such period as he may deem appropriate; and no payment may be made under this title with respect to any item or service furnished by such physician or practitioner during the period of such suspension. The provisions of paragraphs (2) and (3) of subsection (d) shall apply with respect to determinations made by the Secretary under this subsection.

[(2) In any case where the Secretary under paragraph (1) suspends any physician or other individual practitioner from participation in the program under this title, he shall—

[(A) promptly notify each single State agency which administers or supervises the administration of a State plan approved under title XIX of the fact, circumstances, and period of such suspension; and

[(B) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such physician or practitioner of the fact and circumstances of

such suspension, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health, Education, and Welfare fully and currently informed with respect to any actions taken in response to such request.]

(e) No payment may be made under this title with respect to any item or service furnished by a physician or other individual during the period when he is barred pursuant to section 1127 from participating in the program under this title.

* * * * * * *

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

SEC. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2), or whether a laboratory meets the requirements of paragraphs (10) and (11) of section 1861(s), or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p)(4). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, or home health agency (as those terms are defined in section 1861) may be treated as such by the Secretary. [Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement.] Within 90 days following the completion of each survey of any health care facility, rural health clinic, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating the compliance of each such health care facility, rural health clinic, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, rural health clinic, laboratory, clinic, agency, or organization.

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a) * * *

* * * * * * *

(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which has been certified for participation in a plan, approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act to deny payment under title XIX) with respect to any individual admitted to such facility after a date specified by him.

(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of section 1861(j) on the date specified in such clause, the Secretary shall terminate such facility's agreement or provide for termination of such facility's certification, notwithstanding the provisions of paragraph (2) of subsection (b), effective with the first day of the first month following the month specified in such clause.

* * * * * * *

[PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

[SEC. 1876. (a)(1) In lieu of amounts which would otherwise be payable pursuant to sections 1814(b) and 1833(a), the Secretary is authorized to determine, by actuarial methods, as provided in this section, but only with respect to a health maintenance organization with which he has entered into a contract under subsection (i), a per capita rate of payment—

(B) shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this section with the organization; and

(C) shall contain such other terms and conditons not inconsistent with this section as the Secretary may find necessary.

(6) The Secretary may not enter into contract with a health maintenance organization under this section if a former contract with that organization under this section wes terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

(7) The authority vested in the Secretary by this subsection may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

PENALTIES

SEC. 1877. (a) * * *

(b)(1) Whoever *knowingly and willfully* solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever *knowingly and willfully* offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

* * * * * * *

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

SEC. 1883. (a)(1) Any hospital (other than a hospital which has in effect a waiver of the requirement imposed by section 1861(e)(5)) which has an agreement under section 1866 may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute post-hospital extended care services.

(2)(A) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this section shall bet based upon the reasonable cost of the services as determined under subparagraph (B).

(B)(i) The reasonable cost of the services consists of the reasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services (determined under clause (iii)).

(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this section is equal to the product of (I) the number of patient days during the year for which the services were furnished, and (II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the previous calendar year under title XIX to skilled nursing facilities located in the State in which the hospital is located and which have agreements entered into under section 1902(a)(28).

(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(b) The Secretary may not enter into an agreement under this section with any hospital unless the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 1521 of the Public Health Service Act) for the State in which the hospital is located.

(c) An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866 (unless the hospital fails to satisfy the requirements specified in subsection (b)) and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866, or where there is in effect for the hospital a waiver of the requirement imposed by section 1861(e)(5). A hospital whose agreement under this section has been terminated shall not be eligible to undertake a new agreement until a two-year period has elapsed from the termination date.

(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if

those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

(e) During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement received for routine services from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine title XVIII reimbursement for routine hospital services.

(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

(g) The Secretary shall prescribe by regulation an alternative method for determining the amount of the reasonable cost of post-hospital extended care services furnished in a distinct part of a hospital certified as a skilled nursing facility under section 1861(j) that is the same method as the method prescribed in subsections (a) and (e) for determining the amount of the reasonable cost for such services furnished by a hospital that uses beds interchangeably for either acute or long-term care and shall approve the use of this method when a hospital can demonstrate that its use would contribute significantly to the more efficient or effective administration of this part and would be in the interest of program beneficiaries.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

Sec. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * * *

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary

for the purposes specified in the first sentence of section 1864 (a)), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, [and]

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions[;], *and*

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the requirements of section 1861(e)(9) or paragraphs (10) and (11) of section 1861(s);

(10) provide—

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI;

(B) that the medical assistance made available to any individual described in clause (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause (A); and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under title XVI, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible

therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A)

* * * * * * *

(13) provide—

(A) (i) for the inclusion of some institutional and some noninstitutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, for the inclusion of at least the care and services listed in [clauses (1) through (5)] *paragraphs (1) through (5) and (17)* of section 1905(a), and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in [clauses (1) through (5)] *paragraphs (1) through (5) and (17)* of section 1905(a) or

(ii) (I) the care and services listed in any 7 of the [clauses numbered (1) through (16)] *paragraphs numbered (1) through (17)* of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such facility, and

(D) for payment (*except where the State agency is subject to an order under section 1913*) of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent

with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII, *except that in the case of hospitals reimbursed for services under part A of title XVIII in accordance with section 1814 (b) (3), the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section;* and

(E) effective July 1, 1976, for payment (*except where the State agency is subject to an order under section 1913*) of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary; and

* * * * * * *

(14) effective January 1, 1973, provide that—

(A) in case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or who meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)—

(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in [clauses (1) through (5) and (7)] *paragraphs (1) through (5), (7), and (17)* of section 1905(a), will be imposed under the plan, and

* * * * * * *

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, based on the variations between shelter costs in urban areas and in rural areas) for

determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account (*except as provided under subsection* (*i*)) only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him supplemental security income benefits under title XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

* * * * * * *

(23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provided that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a pre-payment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) (*A*) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic, *or* (*B*) *during the three-year period beginning on the date of enactment of this clause, has made arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905*(*a*)(*3*), *if the Secretary has found that* (*i*) *adequate services will be available under such arrangements,* (*ii*) *such laboratory services will be provided*

only through laboratories (I) which meet the requirements of the section 1861(e)(9) or paragraphs (10) and (11) of section 1861(s), and such additional requirements as the Secretary may require, (II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefit under this title or under part A or part B of title XVIII, and (iii) charges for services provided under such arrangements are made at the lowest rate charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such services) for comparable services by the provider of such services, or, if charged for on a unit price basis, such charges result in aggregate expenditures not in excess of expenditures that would be made if charges were at the lowest rate charged for comparable services by the provider of such services;

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by the appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the penultimate sentence of this subsection; and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section1864 (a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, *except that the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;*

* * * * * * *

[(35) provide that any intermediate care facility receiving payments under such plan complies with the requirements of section 1124;]

(35) provide that any disclosing entity (as defined in section 1124(a)(2)) receiving payments under such plan complies with the requirements of section 1124;

* * * * * * *

[(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of the State plan is notified by the Secretary under section

1862(e)(2)(A) that a physician or other individual practitioner has been suspended from participation in the program under title XVIII, the agency shall promptly suspend such physician or practitioner from participation in the plan for not less than the period specified in such notice, and no payment may be made under the plan with respect to any item or service furnished by such physician or practitioner during the period of the suspension under this title;]

(39) provide that the State agency shall bar any specified individual from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1127, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization; [and]

(41) provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary of such action. [.]; *and*

(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1128(a); and

(43) if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician (or any other physician with whom he shares his practice) did not personally perform or supervise, include provision to insure that payment under the State plan for such laboratory services not exceed the payment authorized for such services by section 1842(h).

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration

of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)).

For purposes of paragraphs (9)(A), (29), (31), and (33), and of section 1903(i)(4), the term "skilled nursing facility" and "nursing home" do not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV and who for such month was entitled to monthly insurance benefits under title II shall for purposes of this title only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92–336 not been applicable to such individual. *In the case of an individual who, for a month after May 1980, was determined to be eligible for medical assistance under the plan and was receiving a monthly insurance benefit under title II of this Act or under the Railroad Retirement Act of 1974 or an annuity under subchapter III of chapter 83 of title 5, United States Code (relating to civil service retirement), or compensation, dependency and indemnity compensation, or a pension, under chapter 11, 13, or 15 of title 38, United States Code (relating to veterans and other persons) and who (but for this sentence) would have become ineligible for such medical assistance in the subsequent month because of an increase in the amount of such benefit or annuity due to an increase in a cost-of-living or price index, or because of an annual, general increase in the amount of such compensation or pension, respectively, becoming effective in such subsequent month, for purposes of establishing the individual's eligibility for medical assistance under the plan for such subsequent month (and each month thereafter until the first month in which the individual otherwise becomes ineligible for such assistance) there shall not be included in the individual's income any such increase in the amount of such benefit, annuity, compensation, or pension which becomes effective in or after such subsequent month.*

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement.

* * * * * * *

[(g) The Secretary may waive suspension under subsection (a)(39) of a physician's or practitioner's participation in a State plan approved under this title and of the prohibition under such subsection of payment for any item or service furnished by him

during the period of such suspension, if the single State agency which administers or supervises the administration of the plan submits a request to the Secretary for such waiver and if the Secretary approves such request.]

(h)(1) In adddition to any other authority under State law, where a State determines that a skilled nursing facility or intermediate care facility which is certified for participation under its plan no longer substantially meets the provisions of section 1861(j) or section 1903(c), respectively, and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j) or section 1903(c) (as the case may be), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j) or section 1905(c) (as the case may be), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

(i)(1) Notwithstanding any other provision of this title (including subsection (f), but except as provided in paragraphs (2) and (4)) and to the extent permitted in this subsection, a State plan for medical assistance under this title may provide that an individual shall be ineligible for medical assistance, provided under a State plan approved under this title, for the period specified in paragraph (2) if—

(A) within any twenty-four-month period that begins with or after the twenty-fourth month preceding the month in which he files an application for medical assistance under the plan, the in-

dividual (or another person whose resources are considered in determining the eligibility of the individual) disposed of resources which, if retained, would have caused the individual to be ineligible for such assistance, for the purpose of establishing eligibility for such benefits (and any disposition of resources within such period may be presumed to have been for such purpose unless the State is furnished convincing evidence that the transaction was for some other purpose), and

(B) the sum of—

(i) the current market value of the individual's (or other person's) equity interest in such resources disposed of without any compensation, and

(ii) the difference between the current market value of the individual's (or person's) equity interest in such resources disposed of for compensation and the amount of such compensation,

exceeded $6,000.

(2)(A) Except as provided in subparagraph (B), the period for which an individual is eligible for medical assistance under a State plan by reason of the application of paragraph (1) shall be—

(i) six months, if the sum described in paragraph (1)(B) is less than $12,000,

(ii) twelve months, if the sum described in paragraph (1)(B) is exceeded $12,000 but was less than $30,000, and

(iii) twenty-four-months, if the sum described in paragraph (1)(B) exceeded $30,000,

and shall begin with the month following the month in which such disposition occurred.

(B) A period of ineligibility shall end after the month in which the individual (or other person) either (i) returns the resources, the disposition of which caused the ineligibility to occur or (ii) receives payment equal to the amount of any uncompensated interest described in paragraph (1)(B).

(C) A State plan may provide for the waiver of the requirement of paragraph (1), or the reduction in the period of ineligibility imposed by this paragraph, in such cases as the State determines that such a waiver or reduction is justified.

(3) If the eligibility of a person for medical assistance under this title is dependent upon the eligibility of another individual and that other individual is determined to be ineligible for medical assistance under paragraph (1) for a period of time, the person shall be ineligible for medical assistance for the same period of time.

(4)(A) Except as provided in subparagraph (B), paragraph (1) shall not apply to individuals with respect to whom supplemental security income benefits are being paid under title XVI.

(B) Subparagraph (A) shall not apply to a State which, pursuant to subsection (f), does not provide for medical assistance to all individuals with respect to whom supplemental security income benefits are being paid under title XVI.

(5)(A) Notwithstanding any other provisions of law, if an individual disposes of resources to another person which disposal, under this subsection, could make the individual ineligible for medical assistance

from a State for a period, the State plan under this title may provide for the recovery from such other person of an amount equal to—

(i) the cost of the medical assistance provided to the individual during or after such period, or

(ii) the sum described in clauses (i) and (ii) of paragraph (1)(B) with respect to transactions between the individual and the person for such period,

whichever is less, except that the State may not initiate such an action for recovery more than three years after the last date in such period of ineligibility.

(B) If a State recovers funds under subparagraph (A), it shall provide for notice to the Secretary of the amounts so recovered and the Secretary shall reduce the amount of payments otherwise provided to the State under this title by an amount equal to product of—

(i) the amount so recovered, and

(ii) the Federal medical assistance percentage of the State.

PAYMENTS TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) [and (h)], *(h), and (j)* of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII or who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof); plus

* * * * * * *

(4) an amount equal to 100 per centum of the sums expended with respect to costs incurred during such quarter *and before October 1, 1983* (as found necessary by the Secretary for the proper and efficient administration of the State plan) which are attributable to compensation or training of personnel (of the State agency or any other public agency) responsible for inspecting public or private institutions (or portions thereof) providing long-term care to recipients of medical assistance to determine

whether such institutions comply with health or safety standards applicable to such institutions under this Act; plus

* * * * * * *

(6) subject to subsection (b)(3), [an amount equal to 90 per centum of the sums expended during each quarter beginning on or after October 1, 1977, and ending before October 1, 1980, with respect to costs incurred]
an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to cost incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus

(7) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the performance of a second or third opinion as to necessity and appropriateness of specified elective surgical procedures in the case of a demonstration project described in section 1129(f)(1)(B); plus

[(7)](*8*) an amount equal to 50 per centum of the remainder of the amounts expended such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third

party pursuant to the provisions of its plan in compliance with section 1902(a)(25).

(g)(1) * * *

* * * * * * *

(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before [October 1, 1977,] *January 1, 1978*, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to [the calendar quarter ending on December 31, 1977] *any calendar quarter ending on or before December 31, 1978*, is satisfactory under such paragraph and is valid under paragraph (2).

* * * * * * *

(i) Payment under the preceding provisions of this section shall not be made—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth [and fifth], *fifth, and ninth* sentences of section 1842(b)(3); or

* * * * * * *

[(j)(1) Notwithstanding the preceding provisions of this section, no payment shall be made to a State (except as provided under this subsection) with respect to expenditures incurred by it for services provided by any institution during any period that an order for suspension of payment (as authorized by this subsection) is effective with respect to such institution.

[(2) The Secretary may issue a suspension of payment order with respect to any institution if—

[(A) such institution (i) does not (at the time such order is issued) have in effect an agreement with the Secretary which is entered into pursuant to section 1866; and (ii) did (prior to the time such order is issued) have in effect such an agreement; and

[(B)(i) The Secretary has been unable to collect (or make satisfactory arrangement for the collection of) amounts due on account of overpayments made to such institution under title XVIII; or

[(ii) the Secretary has been unable to obtain from such institution the data and information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII.

[(3) Whenever the Secretary issues any order for suspension of payment under this subsection with respect to any institution, he shall submit a notice of such order to the single State agency (referred to in section 1902(a)(5)) of each State which he has reason to believe does or may utilize the services of such institution in providing medical assistance under a plan approved under this title.

[(4) Any order for suspension of payment issued with respect to any institution under this subsection shall become effective, in the case of any State plan approved under this title, on the 60th day after the date the State agency (referred to in section 1902(a)(5)) administering or supervising the administration of such plan receives notice of such order submitted pursuant to paragraph (3). Any such order shall cease to be effective at such time as the Secretary is satisfied that the institution is participating in substantial negotiations which seek to remedy the conditions which gave rise to his order of suspension of payments, or that the amounts (referred to in paragraph (2)) are no longer due from such institution or that a satisfactory arrangement has been made for the payment by such institution of any such amounts. Upon the determination of the Secretary that any such order with respect to any such institution shall cease to be effective, he shall forthwith notify each State agency to which he has theretofore submitted notice under paragraph (3) with respect to such institution.

[(5) Whenever any order which has been issued by the Secretary under the preceding provisions of this subsection with respect to an institution ceases to be effective, any payment to which any State would (except for the preceding provisions of this subsection) have been entitled under this section on account of services provided by such institution shall be made to such State for the month in which such order ceases to be effective.]

(j) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1913.

* * * * * * *

(n) The State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organization, or agency for purposes of participation under the State plan, or otherwise to approve an institution, organization, or agency for such purposes, if any person, who has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such institution, organization, or agency, is a person described in section 1126(a) (whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1866 [or is

subject to a suspension of payment order issued under subsection (j)] of this section; and, notwithstanding any other provision of this section, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization, or agency did not fully and accurately make any disclosure required of it by section 1126(a) at the time such contract or agreement was entered into or such approval was given.

* * * * * * *

DEFINITIONS

SEC. 1905. The purposes of this title—

(a) The term "medical assistance" means payment of part or all of the costs of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or Part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are

(i) under the age of 21,

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child, except for section 406(a)(2), is (or would, if needy, be) a dependent child under part A of title IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI, or

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

* * * * *

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h); [and]

(17) services furnished by a nurse-midwife (as defined in subsection (m)) which he is legally authorized to perform under State

law (or the State regulatory mechanism provided by State law), whether or not he is under the supervision of, or associated with, a physician or other health care provider; and

[(17)] *(18)* any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution), or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well being of such individual.

(b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that [(1)] the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum [, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum]. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1110(a)(8). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).

* * * * * * *

(m) The term "nurse-midwife" means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary, and performs services in the area of management of the care of mothers and babies (throughout the maternity cycle) which he is legally authorized to perform in the State in which he performs such services.

* * * * * * *

PENALTIES

SEC. 1909. (a) * * *

* * * * * * *

(b)(1) Whoever *knowingly and willfully* solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilt of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever *knowingly and willfully* offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

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CERTIFICATION AND APPROVAL OF SKILLED NURSING FACILITIES AND OF RURAL HEALTH CLINICS

SEC. 1910. (a) * * *

* * * * * * *

(c)(1) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

(2) Any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for

purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.

* * * * * * *

WITHHOLDING OF FEDERAL SHARE OF PAYMENTS FOR CERTAIN MEDICARE PROVIDERS

SEC. 1913. (a) The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for medical assistance for care or services furnished in any quarter by—

(1) an institution (A) which has or previously had in effect an agreement with the Secretary under section 1866; and (B)(i) from which the Secretary has been unable to recover overpayments made under title XVIII, or (ii) from which the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII; and

(2) any person (A) who (i) has previously accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii), and (ii) during the annual period immediately preceding such quarter submitted no claims for payment under title XVIII or submitted claims for payment under title XVIII which aggregated less than the amount of overpayments made to him, and (B)(i) from whom the Secretary has been unable to recover overpayments received in violation of the terms of such assignment, or (ii) from whom the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such person under title XVIII.

(b) The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this title for any quarter by an amount equal to the lesser of the Federal matching share of payments to any institution or person specified in subsection (a), or the total overpayments to such institution or person under title XVIII, and may require the State to reduce its payment to such institution or person by such amount.

(c) The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to an institution or person, pursuant to subsection (b) until after he has provided adequate notice (which shall be not less than 60 days) to the State agency and the institution or person.

(d) The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall (1) determine

the amount of the Federal payment to which the institution or person would otherwise be entitled under this section which shall be treated as a setoff against overpayments under title XVIII, and (2) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under title XVIII and to which the institution or person would otherwise be entitled under this title.

(e) The Secretary shall restore to the trust funds established under sections 1817 and 1841, as appropriate, amounts recovered under this section as setoffs against overpayments under title XVIII.

(f) Notwithstanding any other provision of this title, an institution or person shall not be entitled to recover from any State any amount in payment for medical care and services under this title which is withheld by the State agency pursuant to an order by the Secretary under subsection (b).

HOSPITAL PROVIDERS OF SKILLED NURSING AND INTERMEDIATE CARE SERVICES

SEC. 1914. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under a State plan approved under this title for skilled nursing facility services and intermediate care facility services furnished by a hospital which has in effect an agreement under section 1883.

(b)(1) Payment to any such hospital, for any skilled nursing or intermediate care facility services furnished, shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under this title to skilled nursing and intermediate care facilities located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(2) With respect to any period for which a hospital has an agreement under section 1883 in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services received from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine title XIX reimbursement for routine hospital services.

(c) The State plan may provide an alternative method for determining the amount of payment for long-term care services furnished in a distinct part of a hospital (where the conditions described in section 1883(g) are met) that is the same as the method prescribed in subsection (b) of this section for determining the amount of payment for such services furnished by a hospital that uses beds interchangeable for either acute or long-term care.

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SECTION 3 OF PUBLIC LAW 95-210

AN ACT to amend titles XVIII and XIX of the Social Security Act to provide payment for rural health clinic services, and for other purposes

III. EXPLANATION OF PROVISIONS

A. TITLE VIII: SPENDING REDUCTIONS

1. SUBTITLE A: MEDICARE AND MEDICAID PROGRAM SAVINGS

a. Medicare Amendments of 1980 (Provisions of H.R. 3990) [1]

HOME HEALTH SERVICES (SECTION 802)

Since the beginning of the medicare program, home health benefits have been available under both part A—hospital insurance—and part B—medical insurance.

To be eligible for home health care, the beneficiary must be: (1) essentially confined to his home, (2) under the care of a physician, and (3) in need of skilled nursing care, speech therapy, or physical therapy. If all these requirements are met, an individual is eligible for the full range of home health services.

Title VIII amends the medicare home health benefit in the following manner: (1) unlimited visits are to be available under both parts A and B; (2) the present three-day prior hospitalization requirement under part A is eliminated; (3) home health benefits under part B will no longer be subject to the $60 deductible; (4) the need for occupational therapy will be included as one of the qualifying criteria for the home health benefit; and (5) the present requirement that proprietary home health agencies can participate in medicare only in those States that license home health agencies is eliminated. In addition, Title VIII establishes additional standards and reimbursement guidelines for the effective administration of the home health benefit.

Elimination of the limits on the number of visits under parts A and B.—Beneficiaries are presently eligible for 100 visits per benefit period during the year following a hospital stay of at least three days under part A and 100 visits per calendar year under part B. Title VIII eliminates the limitation on visits under each part.

Elimination of the three-day prior hospitalization requirement under part A.—In order to receive home health benefits under part A, beneficiaries must be hospitalized for at least three consecutive days. Elimination of this requirement will be particularly helpful to the more than 1.1 million beneficiaries who have only part A of medicare; presently they do not have access to the home health benefit unless they have met this prior hospitalization requirement.

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[1] The Committee on Ways and Means favorably reported H.R. 3990 to the House (H. Rept. 96–588, Part I) on November 5, 1979. A supplemental report (H. Rept. 96–588, Part II) was filed by the Ways and Means Committee on December 5, 1979. The Committee on Interstate and Foreign Commerce favorably reported the bill with amendments (H. Rept. 96–588, Part III) on March 18, 1980.

Elimination of the part B $60 deductible with respect to home health services.—In 1972, legislation was enacted which exempted the part B home health benefit from the 20-percent coinsurance applicable to other part B services. Elimination of the part B $60 deductible with respect to such services will eliminate the remaining patient cost-sharing on home health services.

Addition of the need for occupational therapy as one of the criteria qualifying a beneficiary for home health benefits.—Under present law, only the need for skilled nursing care or speech or physical therapy qualifies a beneficiary for home health benefits. Occupational therapy services are available as a home health benefit only after the beneficiary has otherwise qualified. Occupational therapy, like physical therapy or speech therapy, is a skilled health service which assists a patient who is recovering from an illness or injury in making the transition between an institution and self-care in the home. Accordingly, Title VIII recognizes occupational therapy as the fourth skilled service which will qualify beneficiaries for the home health benefit.

Elimination of the licensing requirement for proprietary home health agencies.—By law, proprietary, or for-profit, home health agencies are eligible to participate in the medicare program only where the agency is licensed pursuant to State law and meets such additional standards and requirements as may be prescribed in regulations. Since only 24 States presently license home health agencies, there are a number of States in which proprietary agencies are precluded from participating in the medicare program. With respect to additional standards which by law may be imposed on proprietary home health agencies, it is required that such agencies offer skilled nursing services and one other therapeutic service directly, whereas public and nonprofit agencies are allowed to contract for either the skilled nursing service or the other therapeutic service. Title VIII eliminates the special licensing requirement under medicare pertaining to proprietary home health agencies and the authority of the Security of HHS to establish additional standards solely on the basis of the tax status of the agency.

In addition to the liberalizations in the home health benefit, Title VIII also includes several provisions to assure the more efficient and economical administration of the benefit.

Regional intermediaries for home health agencies.—Title VIII requires the Secretary of HHS to establish regional intermediaries for home health agencies. The Committee has found a wide variation in administrative and reimbursement practices among intermediaries with respect to home health providers. This is largely attributable to the small proportion of an intermediary's medicare business that is devoted to this particular type of provider. As a consequence, little expertise is developed in this area and there is no way of making meaningful comparisons of the utilization and cost of various agencies. Consolidation of the medicare home health business among a smaller number of intermediaries will enable intermediaries to focus more resources on the administration of the benefit and develop uniform cost and performance criteria.

Title VIII provides that, in the case of those hospital-based home health agencies which use the same medicare intermediary used by their affiliated hospital, the Secretary is to reassign the home health

agency to another intermediary only where he determines such a reassignment would result in more effective and efficient administration of the program.

Home health aides.—Title VIII modifies the present provision of the home health benefit which covers services furnished by a home health aide on a part-time or intermittent basis by requiring that such aides meet certain qualification standards. It has come to the attention of the Committee that, in some cases, aides have been used to provide services under the medicare home health benefit who have no prior training or experience in caring for the medical needs of the aged and disabled. This has been found to be particularly true in the case of some agencies which do not directly employ home health aides, but contract out for those services, sometimes with personnel agencies which supply general temporary help. Title VIII makes it clear that home health aides, whether employed directly by the home health agency or made available through contract with another entity, must have completed a training program approved by the Secretary.

Physician certification.—Title VIII requires that the physician who performs the required certification with respect to home health services and establishes and reviews the plan of treatment cannot be a physician who has a significant ownership interest in or a significant financial or contractual relationship with the home health agency that is providing the service to the medicare beneficiary.

The Committee has found that some home health agency patients have had their certifications or plans of treatment signed and authorized by physicians who are medical directors or owners of the provider home health agencies. Title VIII will prevent potential conflicts of interest from arising as part of the certification and plan of treatment process.

Bonding and escrow requirements.—In settling the medicare cost reports after the close of a home health agency's fiscal year, it is sometimes determined that in making interim payments throughout the year the medicare program has substantially overpaid the agency. Since home health agencies are generally established with very little capital investment and have little or no equity, there may be no financial resources available to repay the medicare program. For example, in the case of an agency which serves only medicare beneficiaries, the agency can borrow funds to repay the overpayment and medicare will reimburse the agency for 100 percent of the costs related to the loan.

As in the case with agencies which receive all or a substantial portion of their income from the medicare program, it is not in the best interest of the medicare program to totally or almost totally finance a loan to repay itself. Accordingly, the bill provides the Secretary of HHS authority to establish bonding and escrow requirements for such agencies in order to assure the availability of funds to repay any overpayments. Medicare will not recognize as allowable costs for reimbursement purposes any costs which are incurred in connection with meeting the bonding requirement or establishing an escrow account. To assure that the restricted funds are used to make the repayments, medicare will not recognize as allowable costs, any costs or interest charges incurred in connection with amounts borrowed for the purpose

of repaying overpayments. (This limitation on borrowing expenses is to apply only to agencies subject to the bonding and escrow requirements.) The Committee recognizes, however, that the amounts available from the bond or the escrow account may not be sufficient to repay the entire amount of the overpayment. In cases where the restricted amounts are used but are insufficient, the borrowing costs are to be recognized as allowable costs, to the extent they are reasonable.

Limitations on reimbursement for certan types of contracts.— Title VIII provides that, in the case of contracts entered into after the date of enactment under which services are furnished for or on behalf of the agency, no costs incurred by the agency in connection with such a contract are to be considered allowable costs if either (i) the term of the contract exceeds five years, or (ii) the amount payable under the contract is based on a percentage of the agency's reimbursement for services furnished.

The General Accounting Office has concluded that long-term contracts, as long as—20 to 30 years—which typically provide for management consulting services, are a source of abuse in the medicare program. Similarly, franchise operations have been identified which base their fees on a percentage of reimbursement, with the result that payment under the contract may be considerably more than the actual value of the services furnished. Title VIII requires the home health agencies to follow normal prudent business practices and assures that the program will not have to pay excessive costs.

With respect to existing percentage-of-reimbursement contracts for services, Title VIII limits medicare reimbursement to amounts which are equal to the reasonable value of the service. In adapting these limitations on reimbursement for existing percentage contracts of home health agencies, the Committee intends in no way to diminish any of the Secretary's authority, under current law, to impose limitations on the costs that will be recognized as allowable with respect to contracts entered into by providers of services.

Other administrative requirements.—Title VIII authorizes the Secretary to establish such other administrative requirements for home health agencies as he finds necessary for the effective and efficient operation of the program. It is the Committee's intent to provide sufficient direction to the Secretary of HHS to insure the development of more adequate administrative and reimbursement guidelines and, at the same time, provide the Secretary with authority to establish such additional guidelines or requirements he deems necessary in order to improve the administration of the program. In particular, the Committee expects the Secretary to take the following actions:

Develop and promulgate under the authority of section 223 of Public Law 92-603, where appropriate, limits on specific categories of costs incurred by home health agencies; such limits would be in addition to those overall per visit limits which may already be in effect;

Develop and issue to fiscal intermediaries by January 1, 1981, cost screens which are to be used by the intermediaries in determining whether an agency's overall costs or costs in specific categories are substantially out of line with those of comparable home health agencies;

Develop and issue to the fiscal intermediaries by January 1, 1981, detailed utilization screens which can be used for both reimbursement purposes and identifying potential program abuse;

Develop appropriate mechanisms for assuring that the present standards related to the supervision of home health aides by nurse supervisors are enforced; and

Conduct a comprehensive demonstration program to evaluate alternatives to the present cost reimbursement method for home health services, and report back to the Committee on the progress and findings of the demonstrations by January 1, 1982, and annually thereafter.

The amendments made by this section are effective with respect to services furnished on or after July 1, 1981.

Reciprocal Agreements for Services Furnished Outside the United States (Section 803)

Title VIII authorizes the President to enter into reciprocal agreements with other countries to provide hospital and medical benefits for medicare beneficiaries living or traveling outside the United States.

Under present law, medicare coverage is provided with a few limited exceptions, only for health care services rendered within the United States. These exceptions cover only cases in which the beneficiary needs emergency hospital services while traveling in Canada between the 48 contiguous states and Alaska; or needs hospital services because of a medical problem that arose while traveling or residing within the United States near the border, and a Canadian or Mexican hospital is more accessible than the nearest United States hospital. This limitation on medicare coverage was included in the law because of the administrative problems involved in verifying the medical necessity for services furnished outside the United States, establishing the qualifications of foreign medical practitioners and institutions, and determining the appropriate amount of payments to make for services.

A significant number of medicare beneficiaries are deprived of their medicare benefits during such times as they may be traveling or living outside the United States. Since the basis of the limitation, in present law is administrative, the Committee believes that considerations of equity dictate the development of a reasonably workable arrangement for assuring medicare protection, to the extent feasible, for such beneficiaries.

The Committee recognizes that there are limitations in the approach included in Title VIII to providing coverage outside the United States. The negotiation process is likely to be time-consuming (although Title VIII provides authority, pending the conclusion of an agreement, for the Secretary of HHS to enter into interim arrangements with accredited hospitals in a country if serious negotiations are in progress), and there is the possibility that some countries will choose not to enter into an agreement. Moreover, Title VIII includes certain restrictions on the authority to negotiate such agreements. For example, no reciprocal agreement negotiated under the authority granted by Title VIII may provide entitlement to benefits in the United States for foreign nationals who do not meet medicare's entitlement requirements with respect to age or medical condition (regardless of that individual's status under his country's program), or authorize any individual

to receive benefits in the United States on a reciprocal basis in excess of those benefits provided for medicare beneficiaries. Nevertheless, the Committee believes that the use of reciprocal agreements represents the most effective method at this time to begin to overcome the administrative and technical obstacles that have heretofore precluded any coverage for services furnished to beneficiaries while they are outside the United States.

This section is effective on enactment.

Dentists' Services (Section 804)

Title VIII modifies present law to cover services performed by dentists where those services are presently covered when performed by physicians. Title VIII also covers hospital stays for the performance of noncovered dental services where the severity of the dental procedure warrants hospitalization.

Under present law, services furnished by dentists are covered under part B of medicare but only with respect to: (1) surgery of the jaw or any structure contiguous to the jaw, or (2) reduction of any fracture of the jaw or facial bone. Payment for routine dental services is specifically excluded. However, there are some services which are regularly performed by both physicians and dentists but which are covered under medicare only if performed by a physician. For example, certain procedures and services relating to treatment of oral infections are covered when furnished by a physician but are not covered when furnished by a dentist. Such functions do not involve routine dental care, which is separately excluded under existing law whether performed by a dentist or a physician. It is the Committee's belief that it is appropriate to provide the same coverage for services performed by a dentist (which are within the scope of his state license) that is provided for services performed by physicians. The present exclusion of routine dental services would remain in effect.

The Committee also concluded that present coverage for inpatient hospital services related to certain noncovered dental procedures is inadequate. Under existing law, the test for medicare coverage of the inpatient services is the patient's underlying condition (e.g., history of heart failure). As a result, hospitalization coverage is precluded where, in the judgment of the patient's dentist, the severity of the dental procedure alone requires hospitalization. Accordingly, Title VIII covers hospital stays based on a dentist's (or physician's) certification that hospital inpatient services are necessary for the performance of noncovered dental procedures either because of the severity of the dental procedure or the patient's underlying condition warrants such hospitalization.

This section is effective with respect to services furnished on or after July 1, 1981.

Treatment of Plantar Warts (Section 805)

Title VIII eliminates the present exclusion of services related to treatment of plantar warts.

Under present law, coverage for services related to routine foot care—which is defined as "including the cutting and removal of corns,

warts, or callouses, trimming of nails, and other routine hygienic care"—is specifically excluded.

Warts on the feet (often called plantar warts because they may appear on the plantar surface of the foot), are tumors caused by infectious viral agents. However, because of the routine foot care exclusion in present law, treatment for plantar warts is not a covered service, while the treatment of warts located elsewhere on the body is a covered service. The Committee is concerned about this inconsistency in present law, and Title VIII therefore eliminates the present exclusion of coverage of services related to the treatment of plantar warts.

This section is effective with respect to services furnished on or after July 1, 1981.

Community Mental Health Centers (Section 806)

Title VIII provides that services furnished in qualified community mental health centers is to be reimbursed under part B of medicare on a cost-related basis or on the basis of other tests of reasonableness as are determined by the Secretary of HHS to be appropriate. Up to fifteen outpatient visits per year are to be covered and up to 60 partial hospitalization visits per year are to be covered.

Community mental health centers are not specifically recognized under present medicare law. Services furnished by a community mental health center which is physician-directed are presently covered either as physicians' services or services furnished "incident to" a physician's services (e.g., services of psychologists and other professionals). Services furnished in community mental health centers which are not physician-directed are not generally covered under the medicare program.

Since 1963, the Federal Government has been involved in efforts to develop community mental health centers which offer a range of outpatient mental health services in the expectation that such centers would replace large inpatient institutions as the primary place of treatment for the mentally ill. The current medicare limitations on the coverage of outpatient mental health services are not consistent with this larger objective.

The Committee recognizes that there are differences within the health care community as to the strict applicability of the medical model to the diagnosis and treatment of mental disorders. Thus, while standard medicare terminology may be used for definitional purposes in the bill, this terminology should be understood and applied within the framework of accepted prevailing practices followed by qualified community mental health centers in the provision of mental health services. It is also the intent that periodic review and approval of a plan of treatment be conducted by a center's duly constituted treatment review committee, of which the physician is a member, composed of members of the several disciplines involved in the care and treatment of the patient. In addition, while the physician certification with respect to partial hospitalization visits must include a judgment as to the patient's need for institutionalization in the absence of partial hospitalization visits, it is not the intent that such a judgment need imply that institutionalization would otherwise be required immediately.

The use of the term "diagnostic and therapeutic services" in the definition of covered community mental health services is intended to encompass those liaison and coordination services furnished by qualified mental health personnel of the center as part of the overall management of patient care. Title VIII provides that for the purpose of medicare reimbursement, community mental health services are to be furnished by qualified mental health professionals, who meet standards established by the Secretary of Health and Human Services. The Committee intends that a qualified clinical psychologist be defined as one who is licensed in the State or, in a State which does not license clinical psychologists, is legally authorized to perform the services of a clinical psychologist, and who meets such other requirements as are determined necessary by the Secretary. It is the Committee's intent that a qualified clinical psychologist be further defined by the Secretary as one who has a doctorate degree in psychology, and has had at least two years of supervised clinical experience in an organized setting, such as a hospital which has an accredited mental health facility or a Federally-qualified community mental health center, or who has a comparable combination of education and clinical experience. The Committee expects that the Secretary will determine a qualified psychiatric social worker to be one who is licensed by the State where a State has a licensure program, who has a masters' degree from an accredited school of social work, and who has two years of supervised clinical experience. Further, the Secretary is expected to define a qualified psychiatric nurse to be one who is licensed to practice nursing by the State in which he or she functions, who has a masters degree in psychiatric nursing or a related field from an accredited educational institution, and who is certified as a psychiatric nurse by the appropriate certifying body (if any). The Secretary may define, in regulations, other mental health professionals (other than physicians) who would be qualified to furnish services to medicare beneficiaries in community mental health centers. Although the Committee provides the Secretary this flexibility, the Committee expects the Secretary to recognize only those professionals who are clearly qualified to furnish mental health services for the treatment of the mentally ill. In establishing the definitions for these mental health professionals, the Secretary is to specify appropriate education, certification, licensure and experience criteria.

The term "under the case management of a physician" in the community mental health center setting is used to emphasize that daily, "over-the-shoulder" supervision by a physician of all of the services furnished by the center is not appropriate. Case management is intended to imply a process through which a physician and qualified mental health professionals collaborate in order to ensure equality of patient care and treatment. Case management requires that the physician monitor and evaluate all medicare patients, be available for advice and consultation as needed, and provide direction and supervision to the qualified mental health professionals concerning the medical services to be provided. This process may take place apart from the direct service contact of the qualified mental health professional. This process must also be regularly scheduled, depending upon the patient's condition, and documented in the patient's record.

Title VIII extends recognition as qualified providers only to those centers meeting the definition of and requirements for a community mental health center contained in the Community Mental Health Center Act and the regulations prescribed thereunder. However, Title VIII directs the Secretary to develop comparable standards, in consultation with appropriate professional organizations, (including the Joint Commission on Accreditation of Hospitals), for the possible future coverage of other outpatient mental health centers, and to submit to the Congress such recommendations as he finds appropriate with respect to coverage and standards for such centers. Such recommendations are to be submitted within 24 months after enactment.

This section is effective with respect to a community mental health center's first accounting period which begins on or after July 1, 1981.

Comprehensive Outpatient Rehabilitation Facility Services (Section 807)

Comprehensive outpatient rehabilitation centers are to be recognized under Title VIII as providers of services under medicare. Such rehabilitation centers could be public or private institutions primarily engaged in providing under medical direction diagnostic, therapeutic, and restorative services to outpatients and are required to meet specified conditions of participation.

Under present law, medicare covers certain rehabilitation services in a variety of settings under various coverage provisions. Such services are included among the services that may be reimbursed on a charge basis as "incident to" the services of a physician. Outpatient physical therapy and outpatient speech pathology services are covered on a cost-related basis when furnished by a clinic, rehabilitation agency or public health agency; however, this coverage provision does not include occupational therapy and other rehabilitation services. Services furnished by an independently practicing physical therapist in the office setting are also covered, but there is an annual limit on the amount medicare will pay for such services.

Present law does not provide coverage for a broad array of rehabilitation services where these are furnished on an outpatient basis in a coordinated fashion by a comprehensive outpatient rehabilitation facility. Title VIII makes provision for such coverage, including the coverage of occupational therapy, by recognizing such facilities as providers of services if they meet specified conditions of participation and by providing reimbursement under part B for the services ordinarily furnished by such facilities based on the costs they incur in furnishing covered services to medicare beneficiaries.

This section is effective with respect to a facility's first accounting period which begins on or after July 1, 1981.

Optometrists' Services (Section 808)

Title VIII provides coverage for services furnished by optometrists to aphakic patients (patients without the natural lens of the eye). Also, the Secretary of HHS is directed to report to the Congress

as to specific legislative recommendations for implementing coverage for services furnished by optometrists to cataract patients.

Present law specifically excludes payment for eyeglasses, eye examinations for the purposes of prescribing, fitting, or changing eyeglasses, and procedures performed to determine the refractive state of the eye. However, post-surgical lenses for aphakic patients are covered as prosthetic devices when prescribed by a physician or an optometrist. While medicare covers the cost of a physician's examination to determine the need for the prosthetic lenses, the cost of the same service when furnished by an optometrist is not covered. The only services for which optometrists may be reimbursed under present law are dispensing services in connection with the actual fitting and provision of such prosthetic lenses.

Title VIII provides for payment under medicare for examination services performed by optometrists in connection with the condition of aphakia. Optometrists are to be reimbursed for such services only if they are licensed to perform them by the State in which they practice. Additionally, as under current law, payment will not be made for refractions whether performed by an optometrist or an ophthalmologist.

The Department of HHS has recommended that, while optometrists' services related to aphakia should be covered at the present time, it would be inappropriate to provide coverage for services furnished by optometrists to cataract patients until the Department has had an opportunity to resolve a number of administrative issues related to such matters as delivery pattern changes, utilization controls, an operational definition of cataracts, and cost controls. In light of these considerations, Title VIII directs the Secretary to complete his analysis of the pending administrative issues and submit legislative recommendations with respect to medicare reimbursement for optometrists' services for cataract patients.

This section applies to services furnished on or after July 1, 1981.

Antigens (Section 809)

Title VIII allows payment to an allergist for the preparation of a reasonable supply of an antigen, including a supply forwarded to another physician or a rural health clinic for administration.

Under present law, medicare coverage of drugs and biologicals (including antigens) is limited to those drugs and biologicals which (a) cannot be self-administered, (b) are commonly furnished in physicians' offices incident to a physician's professional service, and (c) are commonly either rendered without charge or included in the physician's bill. Thus, the cost of antigens can be covered, but only where their preparation and administration is an integral part of the allergist's service and represents an expense to him. Title VIII allows payment to an allergist for the preparation of a reasonable supply of antigen, including a supply forwarded to another physician or a rural health clinic for administration.

In the case of a beneficiary who lives some distance from his allergist, the allergist diagnoses the patient's allergy and prepares an antigen with which to treat it; and often, the patient's family physician per-

forms the actual administration of the antigen. Under present law, however, the cost of the antigen is not covered unless the allergist who prepared the antigen also administers it. This creates a financial hardship for a beneficiary who lives too far from his allergist to travel back and forth for the regular administration of the antigen, since he must pay for the antigen himself. Title VIII remedies this problem by allowing payment for the antigen even where the allergist does not administer it.

This section is effective on enactment.

Payment Where Beneficiary Not at Fault (Section 810)

Title VIII requires the Secretary of HHS to make payment where a medicare beneficiary who medically required a higher level of care was erroneously placed in a distinct part of an institution designated to offer a lower level of care.

Under present law, a hospital may designate a "distinct part" of its facility (i.e., an entire, physically identifiable unit consisting of all the beds in that unit, such as a separate building, a floor, ward or wing) and have it qualify for participation in medicare as a skilled nursing facility. Patients located in the "distinct part" skilled nursing facility are entitled to skilled nursing facility benefits, but not hospital benefits. (The purpose for permitting such distinct parts is to assure ease of transfer while maintaining continuity of medical supervision for patients who no longer require hospital services but who do require skilled nursing facility care.)

A skilled nursing facility may similarly designate a "distinct part" which participates in medicare as a skilled nursing facility, while the remaining part of the institution serves as a nonparticipating domiciliary or intermediate care facility. Only patients located in the participating skilled nursing facility distinct part are entitled to medicare skilled nursing facility benefits.

There have been instances in which a patient who requires inpatient hospital services has been inadvertently or erroneously placed in a bed in the skilled nursing facility distinct part of the hospital as a result of a professional or administrative error in judgment. In such cases, the beneficiary's claim for medicare hospital benefits has been denied. Similarly, there have been instances in which nursing home patients have been placed, on the basis of erroneous professional or administrative judgments, in beds in the nonparticipating part of the facility, thus depriving them of their entitlement to skilled nursing facility benefits. In neither case of this type is the beneficiary in a position to make a choice or influence the action taken by the facility or hospital.

Under present law, beneficiaries must bear the adverse consequences resulting from erroneous professional judgment as to the appropriate level of care required and erroneous or inadvertent provider administrative actions in the placement of a patient. Accordingly, Title VIII requires the Secretary to make payment in such situations—on a case-by-case basis—where he determines that the beneficiary medically-required the higher level of care that should have been provided. Thus, payment is to be made under this provision where

the erroneous transfer is caused by: (1) an action of a utilization review committee, a professional standards review organization, a fiscal intermediary, or (2) a provider of services which, acting in good faith, inadvertently or erroneously assigned the patient to the wrong bed.

It is the Committee's intent that this authority to provide payment for certain noncovered services be used in appropriate cases only; that is, where it is clear that an error has been made. It is expected that the Secretary of HHS will take all necessary steps to assure that this provision is not abused.

This section is effective on enactment.

Flexibility in Application of Standards to Rural Hospitals (Section 811)

Title VIII authorizes the Secretary of HHS to apply medicare standards more flexibly to rural hospitals to take into account the availability of qualified technical personnel, the scope of services furnished, and the economic impact of structural standards which, if rigidly applied, would result in unreasonable financial hardship for a rural hospital. However, this authority may be exercised only to the extent that such differential application of the standards does not jeopardize or adversely affect the health and safety of patients.

Under present law, to participate in medicare, a hospital must satisfy certain statutory conditions of participation relating to health and safety standards, physical plant, organizational arrangements, and qualified medical, nursing, and technical staff. The Secretary is authorized to prescribe additional requirements he finds necessary in the interest of the health and safety of patients. (Many requirements relating to fire and safety precautions have been promulgated in accordance with this regulatory authority.) Until December 31, 1978, authority existed for the Secretary to waive the statutory 24-hour registered professional nursing service requirement in the case of a rural hospital where he determined the hospital was making a good faith effort to comply with the 24-hour requirement but such compliance was impeded by a lack of qualified nursing personnel in the area.

Many professionals contend that medicare's health and safety standards are designed primarily for large urban hospitals and that, consequently, the rigid application of these standards to rural hospitals, many of which provide a lesser range of services and have limited access to the services of technical personnel, creates unnecessary financial and management burdens. While the Committee does not share the view that differient or lesser standards ought to be applied to rural hospitals—since the intent of requiring compliance with basic standards is to uniformly assure the safety and quality of care for all patients—the Committee does believe it is necessary to provide some flexibility in the application of national standards. Such flexibility, however, would be permissible only to the extent that it does not jeopardize or adversely affect the health and safety of patients.

Under Title VIII, it will still be necessary for the Secretary to assure that there is compliance with appropriate quality and safety requirements. For example, with respect to the requirements for nursing

services, the Secretary could provide for a temporary waiver of the requirements but only for such period as he determines that the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area, a registered nurse is present on the premises to render or supervise the nursing service during at least the regular daytime shift, and the employment of such nursing personnel as are available to the facility during such temporary period would not adversely affect the health and safety of patients. Similar tests are to be applied by the Secretary with respect to other types of technical personnel, including tests related to the scope of services furnished by the facility and the facility's good faith efforts to fully comply with personnel requirements. The underlying premise, however, is that the Secretary will exercise the authority herein granted to apply standards with some flexibility only when he is satisfied that the health and safety of patients will not be jeopardized and that those services rendered by the affected facilities are delivered in a manner that is consistent with reasonable standards for such facilities.

This section is effective on enactment.

Certification and Utilization Review by Podiatrists (Section 812)

Under Title VIII, podiatrists, acting within the scope of their practice, are to be recognized by medicare for purposes of physician certification and participation as physicians in utilization review. This recognition will extend where consistent with State law and the policies of the health care institutions involved.

As a condition of payment for hospital and other services covered under medicare, existing law requires that a physician certify as to the medical necessity for the service. Also, medicare requiries that the utilization review committee of a hospital or skilled nursing facility include at least two physicians. A podiatrist does not qualify as a "physician" for either purpose.

Since medicare covers as "physicians' services" the services performed by podiatrists within the scope of their practice, the committee concluded that medicare should also recognize podiatrists as physicians for purposes of physician certification and participation in utilization review.

Title VIII extends this recognition to certification and utilization review activities that are consistent with the functions the podiatrist is legally authorized to perform in the State where he practices, and where this recognition is consistent with the policies of any health care institution that is involved. With respect to utilization review, a podiatrist acting as a physician member of a utilization review committee will not take the place of an M.D. or osteopath as one of the two required physician members of the committee.

This section is effective on enactment.

Physician Treatment Plan for Speech Pathology (Section 813)

Title VIII repeals the existing medicare requirement that a physician establish a detailed plan of treatment for speech pathology services.

The Social Security Amendments of 1972 provided for coverage of speech pathology services furnished on an outpatient basis in an organized setting such as a clinic, a rehabilitation agency, or a public health agency. Prior to 1972, outpatient speech pathology services were covered only when furnished by an approved hospital, skilled nursing facility, or home health agency. Present law requires that the patient be referred to the speech pathologist by a physician and that the physician establish and periodically review a plan of treatment which specifies the amount, duration and scope of services to be furnished.

Since speech pathology involves highly specialized knowledge and training, physicians generally do not specify in detail the services needed when referring a patient for such services. As a result, Title VIII allows either the physician or the speech pathologist to establish the plan of treatment so as to conform to medicare law and related program policy to actual practice among the professions. The requirement for physician referral and periodic physician review of the plan of treatment is retained.

This section is effective on enactment.

Payment for Physicians' Services Where Beneficiary Has Died (Section 814)

Title VIII authorizes medicare reimbursement for physicians' services rendered to a medicare patient before his death, on the basis of an unpaid bill, to an individual who has assumed the legal obligation to pay for the physician's services.

Under present law a beneficiary who has received physican services which are reimbursable under medicare can either; (1) send medicare an itemized bill, whether paid or unpaid, and be reimbursed directly by the program, or (2) assign the right to receive payment to the physician who provided the service. Where a beneficiary dies before he or she has executed an assignment of the bill, payment may be made directly to the physician only if he agrees to accept the medicare-determined reasonable charge as payment in full. (He may collect from the beneficiary only the applicable deductible and coinsurance amounts.) If the physician does not agree to this procedure, present law authorizes medicare reimbursement to the estate or the survivors of the deceased beneficiary, but only if the bill has been paid.

The Committee believes that the requirement that the physician's bill must be paid (where the assignment method is rejected by the physician) before medicare can make reimbursement often presents a significant financial burden for survivors of the deceased beneficiary. Thus, in cases where a physician does not agree to accept assignment on a claim for payment of services furnished to a deceased beneficiary, Title VIII allows payment on the basis of an unpaid bill. Payment is to be made only to an individual who presents evidence that he has assumed the legal obligation to pay for the physician's services.

This section applies only to claims filed on or after the date of enactment.

Presumed Coverage Provisions (Section 815)

Title VIII repeals existing medicare provisions authorizing, by type of diagnosis, presumed periods of coverage for skilled nursing

facility and home health services. Protection against retroactive denials will continue to be afforded by the general waiver of liability provision.

The 1972 Social Security Amendments directed the Secretary of HHS to establish a minimum number of days of care in a skilled nursing facility or visits by a home health agency which would be "presumed" to be covered by type of patient diagnosis. This provision was enacted because skilled nursing facilities and home health agencies were experiencing a high rate of retroactive denials for services they provided on the assumption they would be covered by medicare.

A number of skilled nursing facilities and home health agencies have found the presumed coverage regulations confusing, often mistaking what are minimum days or visits covered as the maximum allowed. And in practice, the regulations carrying out this provision create unnecessary administrative steps for both providers and the program since the problem of retroactive denials has been ameliorated by other means. Another provision of the 1972 Amendments—a more general waiver of liability—has turned out to be a more effective remedy and the presumed coverage provisions are no longer needed. (The Committee notes that, according to Department of HHS statistics, claims filed by skilled nursing facilities and home health agencies under the presumed coverage provision now represent less than one-half of one percent of all claims for payment filed by these providers.)

It is the Committee's intention that since the waiver of liability provision is to be used in all cases in this area, its rules are to be applied flexibly so as not to work undue hardship in cases which had been covered under the presumed coverage approach. In particular, it is intended that care be used in the application of rigid percentage limitations with respect to acceptable denial rates. This is particularly true in the case of those providers of service that have very small numbers of medicare beneficiaries where a denial in one or two cases might have the effect—through strict application of a percentage formula—of denying access to the favorable presumptions embodied in the provision.

The section is effective on enactment.

Payment to Providers of Services (Section 816)

Title VIII repeals the existing medicare provisions under which payments to a provider of services are limited to the provider's customary charges if these charges are lower than reasonable costs. Also, medicare reimbursement to providers of services under part B is to be based on reasonable cost minus the coinsurance amounts charged beneficiaries by the provider.

Although medicare providers of services are generally reimbursed, under present law, on the basis of reasonable costs, the amount of payment is limited to the lesser of the reasonable cost of covered services or the provider's customary charges to the public for such services. A variation of this rule applies to "public" (i.e., governmental) providers of services who render services free of charge or at nominal charges to the public; such providers are reimbursed, pursuant to regulations of the Secretary of HHS, on a basis that provides fair compensation. The rationale for this lower of costs or charges provision

was that it would be inequitable for medicare to pay more for services than the provider charges the general public. However, despite an elaborate set of rules to avoid harsh treatment of certain providers, situations have arisen in which there is a question whether it is good public policy to reduce reimbursement, as this provision requires, to levels below cost—for example, in the case of Easter Seal rehabilitation agencies and community-supported home health agencies. Accordingly, Title VIII repeals the lower of costs of charges provision.

Under another provision of present law, providers of services are paid 80 percent of the reasonable cost for services covered under medicare part B. Providers are authorized to charge beneficiaries a coinsurance amount equal to 20 percent of the reasonable charges (not in excess of their customary charges) for the services in question. The medicare reimbursement amount and the coinsurance amount are determined without reference to each other. Together, they sometimes produce income to the provider in excess of 100 percent of the reasonable cost. This result will be avoided under Title VIII, which provides for payment of 80 percent of the reasonable cost only to the extent that this does not exceed the reasonable cost minus the coinsurance.

These provisions apply to services furnished on or after October 1, 1980.

Limit on Premium Increases Due to Late Enrollment (Section 817)

Title VIII modifies the existing medicare provisions that require premiums for medicare part B (and for optional part A coverage) to be increased by ten percent for each year the beneficiary could have been but was not enrolled, by limiting the premium increase to a maximum of 30 percent.

Under present law, if an individual fails to enroll timely in medicare's medical insurance plan (part B), the otherwise applicable premium amount is increased by 10 percent for each 12 months elapsing between the time he could have enrolled and actually did enroll. A similar premium increase is charged to uninsured persons who do not enroll timely in the hospital insurance plan (part A). There is no limit on the percentage amount the part A or part B premium can be increased due to late enrollment. The purpose of these provisions is to avoid the adverse selection that might occur if substantial numbers of healthy persons delayed enrollment until they were well past age 65 and became ill.

Most people who enroll late do so, not because their health has deteriorated, but for a variety of reasons not related to health. For example, many aged beneficiaries mistakenly believe they have to retire from work before they can enroll and thus enroll long after their initial enrollment period. Others, who are residing outside the country and cannot benefit from part B because of the exclusion of foreign medical care, enroll only upon their return to the United States. Still others decide not to enroll initially because they are covered under their employers' or their spouses' health plan. In many of these cases, the increased premium due to late enrollment could be considerably higher than the expected increase in program costs resulting from late en-

rollment and, in some cases, could produce a total premium that is prohibitive to persons living on reduced retirement income. Title VIII establishes a 30-percent limit on the amount by which parts A and B premiums can be increased due to late enrollment. Such a limit should keep the premium within more affordable reach and yet deter such adverse selection as might still occur.

This section applies to premiums for months after June 1981.

Reenrollment and Open Enrollment in Part B (Section 818)

Title VIII repeals the provision of existing law that permits an individual to reenroll in part B only once.

Title VIII provides for a general, continuous open enrollment period for purposes of enrolling in part B of medicare, the supplementary medical insurance benefits program, and repeals a provision of existing law that permits an individual to reenroll in part B only once.

Under current law, an individual may enroll in Part B of the Medicare program during an initial enrollment period (which begins with the third month before the month in which the individual becomes 65 and extends for seven months). Under current law, if an individual fails to enroll during his or her initial enrollment period, enrollment is possible only during a general enrollment period which occurs January 1 through March 31 of each year. Coverage then becomes effective on July 1. This enrollment arrangement can cause hardship for individuals who may be left without medical care coverage for a period of more than one year until a general enrollment period occurs and the enrollment becomes effective. Title VIII replaces the general enrollment period provisions of current law with a continuous general open enrollment period which will allow an eligible individual who has missed his initial enrollment period to enroll at any time thereafter, with the coverage effective with the third month after the month of enrollment.

Under present law, an individual is permitted to reenroll in part B of the program only once; that is, if he disenrolls twice he is permanently barred from participation in the program. While the original purpose of this provision was to prevent the adverse selection that could occur if individuals were permitted to enroll and disenroll at will whenever there was a change in their health condition, the Committee has found that beneficiaries do not as a rule disenroll from the program without good reason. Accordingly, Title VIII allows unlimited reenrollment in part B. Elimination of this part B requirement also allows unlimited reenrollment under part A.

This section is effective on enactment.

Chiropractors' Services (Section 819)

Title VIII modifies the requirements for chiropractic coverage so that a subluxation can be demonstrated to exist either through X-ray or other chiropractic clinical findings. An X-ray, where taken to diagnose a subluxation, will be covered by medicare.

Under present law, medicare covers only those services of chiropractors which involve treatment of a subluxation (partial dislocation)

by means of manual manipulation of the spine. The existence of a subluxation must be demonstrated by X-ray; however, the cost of the X-ray is not covered when performed by a chiropractor.

The X-ray requirement was intended to control costs by excluding from coverage cases in which a subluxation was not evident on an X-ray. The General Accounting Office has indicated that the extent to which X-rays play a part in claims denial is not known. Although chiropractors must have X-rays available upon request, the X-ray is actually reviewed by medicare carriers in only a small number of cases.

The requirement for an X-ray to demonstrate the subluxation of the spine is not necessary in every case, is possibly hazardous, and—since it is not paid for by the program—represents a significant cost to beneficiaries. Since chiropractors would not ordinarily take X-rays in every case to diagnose subluxation of the spine, the Committee has concluded that it is inappropriate to require X-rays, with their accompanying radiation risks, for administrative purposes. The Committee also believes that it is appropriate to pay for an X-ray where it is a necessary part of the chiropractor's diagnosis.

This section applies to services furnished on or after July 1, 1981.

Increase in Outpatient Mental Health Benefits Under Part B (Section 820)

Title VIII increases reimbursement for outpatient mental health services from the present limit of 50 percent of reasonable charges, up to $250 in actual program payments per year, to 80 percent of reasonable charges, up to $750 in program payments per year. Services furnished by clinical psychologists on an outpatient basis are to be covered, subject to the overall limit on outpatient mental health services, where the patient is referred by a physician.

The present limitation on payment for mental health services, which has been in effect since the enactment of the program in 1965, is no longer realistic because of the substantial increase in the cost of health care services since that time. Increasing the limit on program payment to 80 percent of reasonable charges, up to $750 per year, will substantially increase beneficiary protection.

Outpatient mental health services also are to be made more available to the elderly by covering the services of qualified clinical psychologists. Title VIII defines a qualified clinical psychologist as one who is licensed in the State (or in a State which does not license clinical psychologists, is legally authorized to perform the services of a clinical psychologist) and meets such other requirements determined necessary by the Secretary. It is the Committee's intent that a qualified clinical psychologist will be further defined by the Secretary of HHS as an individual who has a doctorate degree in psychology and has had at least two years of supervised clinical experience in an organized setting such as a hospital which has an accredited mental health facility or a Federally-qualified community mental health center, or who has a comparable combination of education and clinical experience. The Committee expects the Secretary to use, to the extent appropriate, the National Register of Health Service Providers in Psychology which

has been established under the auspices of the American Psychological Association. In addition, the Committee expects the Secretary to designate further what specialty training within the various areas of applied psychology is appropriate for providing therapeutic services to medicare beneficiaries.

Title VIII covers outpatient services furnished by independently practicing psychologists only where the beneficiary has been referred to the psychologist by a physician. There are conflicting views as to the need for and appropriateness of such a requirement. The Committee believes, however, that such a requirement should be retained until sufficient information is available to evaluate the effect of its elimination. The Committee expects the Secretary to conduct a study and submit information within one year after the enactment of this provision, which will enable the Committee to judge whether the continuation of the mandated referral by a physician is appropriate. The Committee expects that the Secretary, in conducting the study, will consult with psychiatrists, psychologists, and physicians in the general practice of medicine with respect to whether the requirement is necessary to assure that the beneficiary receives all appropriate medical and mental health services. The Secretary, in his examination of this issue should also weigh the implication of eliminating the referral requirement for general medicare program policy.

This section is effective with respect to expenses incurred in calendar years beginning with calendar year 1982.

Limitation on Payments to Radiologists and Pathologists (Section 821)

Under Title VIII, the special 100 percent reimbursement (with no deductible) for services to hospital inpatients by physicians in the fields of radiology and pathology is to be limited to physicians who agree to accept assignment for all services furnished to hospital inpatients.

Currently, radiologists and pathologists are reimbursed 100 percent of the reasonable charge for services furnished to inpatients of a hospital. This occurs whether or not the physician accepts assignment. (In accepting assignment, a physician agrees to accept the medicare reasonable charge as payment in full.) Reimbursement for all other covered physicians' services is subject to a 20 percent coinsurance and a yearly $60 deductible.

The provision entitling radiologists and pathologists to 100 percent of the reasonable charge was adopted in the 1967 Social Security Amendments to permit a simplified hospital and physician combined billing arrangement. At the time it was felt that the amendment was needed because of the practice of some hospitals of submitting combined billings for both the physician's services and the hospital's laboratory and radiology services. The latter are reimbursable under part A and the former under part B. Because deductible and coinsurance amounts for the two parts differed, it was difficult not only to allocate the combined charge between parts A and B in individual bills, but also to subject those allocated charges to separate deductibles. It was anticipated that administrative savings would accrue as a consequence of the combined billing arrangement.

Contrary to that anticipation, many of these physicians bill the patient directly, rather than combining their billings with those of the hospital. As a consequence, the physicians receive the benefit of 100 percent reimbursement without the expected benefit to the beneficiary or the medicare program. (If the physician services are billed for by the hospital, the beneficiary is assured that he or she will not have to pay any additional amounts. A physician billing the beneficiary directly can charge and demand payment of more than the medicare reasonable charge.)

This provision requires radiologists and pathologists to accept assignment as the quid pro quo for the waiver of the deductible and coinsurance. Physicians refusing to accept assignment for services provided to medicare inpatients will bill on an unasssigned basis, with the medicare program reimbursing the beneficiary for the reasonable charge, less applicable cost-sharing.

This section applies to services furnished after the sixth calendar month beginning after enactment.

Shortened Part B Termination Period for Certain Individuals Whose Premiums Medicaid Has Ceased To Pay (Section 822)

Title VIII permits an individual whose State buy-in coverage for part B of medicare has ended to terminate part B coverage effective with the month in which he notifies the Health Care Financing Administration (HCFA) that he does not want part B coverage.

Under present law, when State buy-in coverage is terminated, an individual's enrollment in part B is continued automatically unless he requests that his coverage be terminated. After such a request, an individual's coverage may not be terminated until the close of the calendar quarter in which the request is made. This results in the individual's coverage and premium liability continuing for anywhere from 3 to 6 months after the State has ceased its buy-in coverage.

This provision requires States to notify the beneficiary and HCFA of their final decision on or before the effective date the individual's buy-in coverage was terminated (assuming that the State had previously given the individual prior notification of its intent to terminate and an opportunity for a hearing under the due process provisions). Following the State's notification, HCFA also is required to notify the beneficiary that State termination of buy-in had occurred.

This section applies to notices filed after the third calendar month beginning after enactment.

Outpatient Physical Therapy Services (Section 823)

Title VIII increases the present $100 limitation on outpatient services furnished by independently practicing physical therapists to $500.

The $100 limitation in present law, initially imposed in the Social Security Amendments of 1972, was intended to help control program expenditures and reduce the potential for over-utilization of these newly covered services. However, the increases in medical costs since 1972 have resulted in a reduction in the value of the original $100 limit

Medicare Payment Liability Secondary in Certain Automobile Insurance Cases (Section 825)

Under Title VIII, medicare will have residual rather than primary liability for the payment of services required by a beneficiary as a result of an injury or illness sustained in an auto accident where payment for the provision of such services can also be made under an automobile insurance policy. Under this provision, it is expected that medicare will ordinarily pay for the beneficiary's care in the usual manner and then seek reimbursement from the private insurance carrier after, and to the extent that, such carrier's liability under the private policy for the services has been determined.

Under present law, medicare is the primary payor (except where a workmen's compensation program is determined to be responsible for payment for needed medical services) for hospital and medical services received by beneficiaries. This is true even in cases in which a beneficiary's need for services is related to an injury or illness sustained in an auto accident and the services could have been paid for by a private insurance carrier under the terms of an automobile insurance policy. As a result, medicare has served to relieve private insurers of obligations to pay the costs of medical care in cases where there would otherwise be liability under the private insurance contract. The original concerns that prompted inclusion of this program policy in the law—the administrative difficulties involved in ascertaining private insurance liability and the attendant delays in payment—no longer justify retaining the policy, particularly if it is understood that immediate payment may be made by medicare with recovery attempts undertaken only subsequently when liability is established.

In order to avoid excessive administrative costs and efforts in pursuing minor recoveries, the Committee expects the Secretary of HHS to establish in regulations rules regarding the minimum amounts estimated as recoverable and the procedures for seeking recovery from private carriers. Such procedures are to be similar to those currently employed by medicare in seeking recovery in workmen's compensation cases.

This section is effective on enactment.

Hospital Transfer Requirement for Skilled Nursing Facility Coverage (Section 826)

Under Title VIII, the 14-day period within which a medicare beneficiary must be transferred from a hospital to a skilled nursing facility in order to qualify for post-hospital extended care benefits (in a skilled nursing facility) is extended to 30 days. The 14-day limit on readmission to the skilled nursing care facility is also extended to 30 days.

Under present law, medicare coverage of post-hospital care in a skilled nursing facility is ordinarily available only where the beneficiary has been an inpatient of a hospital for at least three consecutive days and has been transferred to the skilled nursing facility within 14 days after discharge from a hospital. As many as 14 additional days (for a total of 28 days) are permitted where admission to the

skilled nursing facility must be deferred because there is no bed available in the skilled nursing facilities ordinarily utilized in the geographic area in which the beneficiary resides. Some administrative complexity is involved in the determination of whether a bed is, in fact, available in the geographic area. Permitting 30 rather than 14 days for transfer to the skilled nursing facility will not only eliminate this administrative complexity, but will also provide a modest liberalization of the hospital transfer requirement.

In addition, present law provides that a beneficiary who leaves a skilled nursing facility can be readmitted to the same or any other participating skilled nursing facility within 14 days without again meeting the 3-day hospitalization requirement. Title VIII also increases that 14-day period to 30 days.

This section is effective on enactment.

Outpatient Surgery (Section 827)

Title VIII provides medicare reimbursement for the cost of ambulatory surgical centers when used to perform certain surgical procedures. In addition, the physician's reasonable charge for performing those same procedures on an outpatient basis is to be reimbursed at 100 percent provided the physician performing the surgery agreed to accept assignment.

Under present law, medicare reimburses 80 percent of a physician's fee for surgery, regardless of the setting in which the surgery is performed—in a hospital, the outpatient department of a hospital, or an ambulatory surgical center. Medicare will also reimburse 100 percent of the facility's cost if the surgery is performed in a hospital and 80 percent of the facility's cost if the surgery is performed in a hospital outpatient department or in a free-standing ambulatory surgical center that is owned by the hospital. However, medicare law prohibits reimbursement for any costs incurred by a surgical facility if the facility is not hospital-affiliated.

There are a number of surgical procedures which are ordinarily performed on an inpatient basis but which can, consistent with sound medical practice, be performed on an outpatient basis for far less cost. Medicare, however, discourages the appropriate use of ambulatory surgery since the facility costs are fully reimbursed only on an inpatient basis and, in the case of all free-standing centers, are not reimbursed at all.

This provision provides 100-percent reimbursement for services furnished by ambulatory surgical facilities for the performance of procedures which, although appropriately performed in a hospital inpatient basis, are determined by the Secretary of HHS to be also safely performed in an ambulatory surgical center. It is not the Committee's intent that this list include surgical procedures which would be performed on an outpatient basis in the absence of the elaborate surgical facilities in an ambulatory surgical center. For example, it would not be appropriate to cover the types of surgical procedures routinely performed in a physician's office in the more costly setting of an ambulatory center. The Committee expects that the ambulatory

center will serve as a setting to be used in lieu of hospital inpatient facilities. The reimbursement authorized under this provision is to be paid only where the ambulatory surgical center agreed to accept the medicare payment as payment in full. The ambulatory surgical center is required to meet certain health and safety standards.

The physician performing such procedures in a free-standing ambulatory surgical center or in the outpatient department of a hospital is to be reimbursed 100 percent of the medicare reasonable charge for the services (including all pre- and post-operative services) furnished in connection with the procedure, provided the physician agrees to accept assignment.

In developing the list of procedures eligible for such reimbursement, the Secretary is required to consult with the National Professional Standards Review Council and appropriate medical organizations, including specialty groups.

This section is effective on enactment.

Technical Renal Disease Amendments (Section 828)

Title VIII amends the end-stage renal disease program to correct a defect in present law which has inadvertently resulted in certain reimbursement problems for nonprofit organizations assisting home dialysis patients. In addition, Title VIII changes the reporting date for the annual report of the Secretary of HHS to the Congress on the medicare renal disease program from April 1, to July 1. Title VIII also provides that the determination of need for a renal dialysis facility made by the State Health Planning and Development Agency shall be conclusive.

Under present law, the Secretary may enter into agreements with providers and facilities to reimburse them for the full reasonable cost of the purchase and maintenance of dialysis equipment used by individuals who dialyze at home. However, certain nonprofit organizations which were engaged in assisting home dialysis patients to obtain and maintain such equipment at the time this provision was enacted in 1977, have been denied reimbursement under this provision.

Under Title VIII, therefore, the Secretary of HHS may enter into agreements with organizations such as State kidney programs and nonprofit institutions to provide machines to beneficiaries through direct purchase. The Committee expects that the Secretary will enter into such agreements with entities that demonstrate to his satisfaction that they can provide dialysis machines and supportive equipment economically and efficiently. Like providers and facilities, these entities are to be reimbursed on the basis of their reasonable costs and are required to provide the Secretary full access to cost and other data and submit reports as required by the Secretary with respect to cost, management and use of equipment. In the event the Secretary finds that such an entity fails to provide equipment efficiently and economically, the Committee expects that the Secretary will terminate the agreement.

Title VIII changes the reporting date for the annual renal disease program reports to allow the Secretary more time to gather and analyze the data required in such reports.

This section is effective on enactment.

Preadmission Diagnostic Testing (Section 829)

Under Title VIII, diagnostic tests performed on an outpatient basis within 7 days of a patient's admission to the hospital are to be reimbursed in full (with no deductibles or coinsurance).

In some cases, the diagnostic tests necessary prior to treatment as an inpatient can be performed on an outpatient rather than inpatient basis. Where this is possible, the patient's length of stay in the hospital can be reduced with substantial savings in hospital expenditures. However, whereas the diagnostic testing provided on an inpatient basis is reimbursed at 100 percent, the same service provided on an outpatient basis is reimbursed at the 80 percent rate. Thus, the patient has an economic incentive to be admitted as an inpatient for the testing.

Title VIII eliminates any such incentive by providing for reimbursement at the 100 percent rate for outpatient diagnostic tests provided within seven days of admission to the same hospital where the outpatient tests are furnished. (Not only the hospital costs, but also the reasonable charges of physicians in the fields of radiology and pathology if the physicians accept assignment of the medicare claim, are to be reimbursed at the 100 percent rate, just as they would be on an inpatient basis.) Because of the administrative difficulty of coordinating claims for tests furnished in a hospital other than the one where the beneficiary is subsequently admitted as an inpatient, the Secretary of HHS is directed to provide for payment-in-full for diagnostic services provided in these settings only to the extent feasible. The Secretary, however, is required to report to the Congress a year after enactment as to the progress in developing the policy necessary to implement this additional coverage.

This section is effective on enactment.

Studies and Demonstration Projects (Section 830)

Title VIII requires the Secretary of HHS to study or conduct demonstrations and report to Congress with respect to the following issues:

Coverage for Orthopedic Shoes.—Under present law, orthopedic shoes and other supportive devices for the feet are generally excluded from medicare coverage. The only situation in which the exclusion does not apply is if the orthopedic shoe is provided as an integral part of a leg brace. However, it would be costly to provide coverage for orthopedic shoes, even if the coverage were limited to cases where a physician certifies that the shoes are medically necessary. This provision directs the Secretary to study and submit legislative recommendations to the Congress no later than January 1, 1981, with respect to the coverage of orthopedic shoes where such shoes are required as an appropriate part of medical treatment.

Expanded Coverage for Services of Clinical Social Workers.—Services furnished by clinical social workers are presently covered by medicare when furnished to inpatients of hospitals and skilled nursing facilities, as home health services for those who are otherwise eligible for home health benefits, and when furnished incident to a physician's service. Under Title VII, clinical social workers' services are also to be covered when furnished in a community mental health center. This provision directs the Secretary to conduct a demonstration project and submit recommendations, no later than 24 months

after enactment, for any legislative changes with respect to additional coverage for services of clinical social workers.

Nutritional Therapy for Renal Disease Patients.—The Secretary is authorized to make further studies, conduct a demonstration project and submit legislative recommendations to the Congress, no later than 24 months after enactment, as to whether the use of nutritional therapy in early renal failure, utilizing (but not limited to) controlled protein substances, can retard or arrest the progression of the disease with a resultant deferment of dialysis. Some recent studies reported in the professional literature have indicated that chronic renal failure may be retarded or even arrested by controlling dietary protein intake. The Committee believes that the potential impact of such nutritional therapy on the treatment of chronic renal failure could be significant. Moreover, the cost of the present dialysis-oriented medicare renal disease program could be somewhat reduced if such a therapeutic approach were found to be viable in a substantial number of cases. The Committee expects that in establishing the demonstration project the Secretary will consult physicians with nutritional expertise who have had experience in treating patients with chronic renal disease.

Expanded Coverage for Respiratory Therapy Services.—Under present law, services furnished by respiratory therapists are covered by medicare when furnished as an inpatient service in a hopsital or skilled nursing facility or as a service furnished by the outpatient department of a hospital. The Committee believes it possible that such services might also be appropriately furnished as a home health service to individuals who are otherwise eligible for home health benefits. Under the provision, the Secretary is directed to study the need for coverage of respiratory therapy services as a home health benefit and recommend, no later than 24 months after enactment, under which circumstances and conditions respiratory therapy services should be covered, for example, by type of medical diagnosis.

100 Percent Reimbursement for Second Opinions for Surgery.—The Committee believes that sufficient evidence exists that obtaining a second opinion can in many cases avoid unnecessary surgery to warrant consideration of providing 100-percent reimbursement for the second opinion. The 100-percent payment, in lieu of the usual 80-percent coverage of the physician's fee, will, it is hoped, encourage more beneficiaries to seek second opinions. There is some concern, however, as to what effect such a higher rate of payment might have on overall program cost. There might also be administrative problems in determining when the 100-percent reimbursement is appropriate. Under the bill, the Secretary is required to evaluate demonstration projects currently being conducted by HHS on 100-percent reimbursement for surgical second opinions and report to the Congress, no later than 12 months after enactment, on the effects on surgical rates, the effect on program expenditures and any problems involved in administering such a program.

Home Health Services of Registered Dietitians.—In recent years, nutritional counseling and management by registered dietitians, particularly for the aged, has been recognized as an important component of patient care. While medicare does recognize for reimbursement purposes the salary of a dietitian employed by a home health agency

to provide general guidance on nutritional matters, no coverage is provided with respect to visits that might be made by the dietitian to the patient's home. To help evaluate alternative possibilities for changing current law, the Secretary is directed to study (and, if necessary, conduct a demonstration project) on questions related to the coverage of dietitian visits, e.g., whether the number of covered visits should be related to diagnosis, and what criteria might be appropriately employed to assure proper utilization. The Secretary is to submit to the Congress a report on the study and any demonstration projects along with any legislative recommendation no later than 24 months after enactment.

Study of Costs of Various Types of Foot Care.—Under present law, there are a number of foot conditions currently excluded as routine foot care that are both pathological and, in many cases, severely disabling rather than merely irritants or inconveniences. The Secretary is directed, therefore, to make a comprehensive analysis of the cost of expanded coverage of foot care, including the cost effects of alternative approaches to improving medicare coverage for specific types of foot conditions. The Secretary is to submit the analysis to the Congress within 24 months after enactment.

This section is effective on enactment.

Provider Reimbursement Review Board (Section 831)

Title VIII authorizes the Provider Reimbursement Review Board to determine, on its own motion or at the request of a provider of services, whether it has jurisdiction over an issue brought before it by the provider. On the basis of a determination by the Board that it is without authority to decide the question (or if the Board fails to render such a determination within 30 days of the provider's request), the provider will be permitted to commence a civil action with respect to the matters in controversy without further administrative review.

Under present law, a provider's dissatisfaction with a particular determination made by its fiscal intermediary on the basis of a regulation issued by the Secretary must first be brought to the Board, even though the Board may not have the authority to reverse or overrule the regulation. (The Board has no authority, for example, to rule on the legality of the Secretary's regulations but it must, nonetheless, conduct a full review of the challenge.) The effect of this process has been to delay the resolution of controversies for extended periods of time and to require providers to pursue a time-consuming and irrelevant administrative review merely to have the right to bring suit in a U.S. District Court. Title VIII addresses this problem by giving medicare providers the right to obtain immediate judicial review in instances where the Board determines that it lacks jurisdiction to grant the relief sought.

This section is effective on enactment.

Access to Books and Records of Subcontractors (Section 832)

Title VIII provides that medicare will not reimburse amounts paid by providers under contracts for services between the provider and any of its subcontractors, whose value or cost over a twelve month

period is $10,000 or more and which are entered into after enactment of the bill, unless such contracts contain a clause providing that the subcontractor shall make available to the Secretary of HHS and the Comptroller General, upon request, the contract, and the books, documents and records of the subcontractor that are necessary to verify the nature and extent of the costs incurred by the provider for a service covered by the specified subcontract. Books, papers and records covered by this provision must be preserved for three years after the furnishing of services pursuant to the contract.

Under present law, the Secretary does not have access to the books and records of medicare subcontractors unless the subcontractor is shown to be related to the provider. Unlike contracts for goods, contracts for services can pose difficult valuation problems. Consequently, without access to subcontractors' books, the detection and prevention of fraud and abuse can be difficult.

The Committee believes that this provision is necessary both to strengthen the Secretary's capacity to effectively preclude or detect fraud and abuse and to conform medicare practice to the prevailing practice of other Federal agencies which buy services in the private sector. Moreover, the provision is moderate in scope since it includes only contracts that have a substantial service component (the intent of the value or cost standard is to permit the Secretary to assess the actual terms of the contract) and applies only to contracts entered into after enactment of Title VIII. By including this provision in Title VIII, it is not the Committee's intent to subject subcontractors to "fishing expeditions" or other unnecessarily burdensome or overly intrusive demands. The Committee expects the Secretary and the Comptroller General to avoid demanding books and records of a subcontractor unless there exists reason to believe that the costs or services of such contractor are in some way excessive or inappropriate, or the appropriateness of the costs cannot be judged without access to the specific books and records requested.

This section is effective on enactment.

Medicare Coverage of Pneumococcal Vaccine and Its Administration (Section 833)

Title VIII authorizes medicare to pay for the pneumococcal vaccine and its administration. In order to encourage utilization of the vaccine, Title VIII waives the co-payment and deductibility provisions of existing law.

Pneumonia is the fifth leading cause of death in the United States, with pneumococcal pneumonia accounting for 54,000 deaths annually. Of this number, 48,600 or 90 percent are in the over 65 age population. Because the elderly are particularly susceptible to pneumococcal pneumonia and because they suffer very serious health consequences if they contract the disease, the Committee feels existing law should be changed.

The new provision provides for payments for pneumococcal vaccine and its administration only where reasonable and necessary for the prevention of illness. This extends to the pneumococcal vaccine pro-

the Secretary will take into consideration, and in appropriate cases, solicit the judgments of the courts with respect to the merits of actions. It is the Committee's judgment that such guidelines can be appropriately developed and applied now.

Enteral Therapy

The Committee is concerned that the medicare program should provide coverage for enteral therapy, a special feeding procedure for persons who are unable to take nourishment through the normal process. Parenteral therapy, where nutrients are fed directly into the vein, is now covered. But coverage for enteral feeding, which may involve use of a shunt into the intestine, a tube, into the stomach, or similar procedures, is sometimes denied for noninstitutionalized patients. The Committee believes that the Secretary of HHS has sufficient authority under current law to provide coverage for enteral therapy, whether provided to institutionalized or noninstitutionalized persons, while instituting sufficient safeguards to assure that coverage for enteral therapy will not lead to payments for a whole range of special dietary arrangements, which could be both costly and unjustified in terms of program expenditures. Therefore, the Committee is directing the Secretary to fully explore current authorities with respect to coverage of enteral therapy for patients who have a blockage which prohibits normal feeding.

b. Medicare and Medicaid Amendments of 1980 (Provisions of H.R. 4000) [1]

Expanded Membership of Professional Standards Review Organizations (Section 842)

Title VIII authorizes each professional standards review organization (PSRO) to offer membership, at its own option, to nonphysician health professionals who hold independent hospital admitting privileges.

Under present law, membership in a professional standards review organization is limited to licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in the organization's area. However, the provision of health care services furnished in a hospital setting may involve orders by independent health professionals other than physicians; for example, dentists and podiatrists. Since such health professionals hold hospital admitting privileges in many jurisdictions and order services for which payment may be made under medicare and medicaid, the Committee believes it is appropriate to provide the opportunity—consistent with established professional relationships in each community—for such professionals to participate in the evaluation of these services as members of the PSRO. It is expected that such membership, where the invitation is extended by the PSRO, would be made available under the same general conditions now applicable to doctors of medicine or osteopathy. And the

[1] The Committee on Ways and Means favorably reported H.R. 4000 to the House (H. Rept. 96–589, Part I) on November 5, 1979. The Committee on Interstate and Foreign Commerce favorably reported the bill with amendments (H. Rept. 96–589, Part II) on April 23, 1980.

same requirements are to apply; no independent health professional is to review services that he or she delivered, for example. Additionally, Title VIII retains the requirement of existing law that only doctors of medicine or osteopathy may make final determinations with respect to the services performed by other M.D.'s or D.O.'s.

The Committee believes that inclusion of consumer representatives on the boards of local PSRO's should be left to the option of such organization. Many PSRO's have already, on a voluntary basis, invited consumer representatives to sit on their boards. The Committee believes that such voluntary actions should be encouraged.

This section is effective on enactment.

Registered Nurse and Dentist Membership on Statewide Council Advisory Group (Section 843)

Title VIII provides that at least one registered professional nurse and one dentist must be included in the membership of the advisory group to each Statewide Professional Standards Review Council.

Under present law, the advisory group to a Statewide Council must be composed of representatives of health care practitioners (other than physicians) and health care institutions. In recognition of the impact the nursing and dental professions have on the delivery and quality of care, the Committee believes it is desirable to require each Statewide Council advisory group to include, in addition to representatives of other appropriate professional disciplines, at least one register d professional nurse and one dentist.

This section is effective 180 days after enactment.

Nonphysician Membership on National Professional Standards Review Council (Section 844)

Under Title VIII, membership of the National Professional Standards Review Council is expanded to include a dentist, a registered professional nurse, and one other nonphysician health professional.

Under present law, membership on the National Council, which advises the Secretary of HHS on policy and administrative matters relating to the PSRO program, is limited to doctors of medicine and osteopathy. The Committee believes, however, that since the National Council is responsible for providing policy and administrative advice on all services covered under medicare and medicaid, including services furnished by nonphysician health professionals, such a limitation on membership detracts from the effective performance of the Council's function. Providing for the membership of representatives of the nursing, dental and other health care professions will enhance the exchange of professional judgments on standards and utilization of services among these disciplines.

The Committee expects that the Secretary, in selecting the member to represent the several nonphysician health disciplines, will develop a selection process that will assure both the equitable rotation of the position among the recognized scientific health care disciplines and the selection of a representative of recognized standing and distinction in his or her chosen scientific field.

This section is effective 180 days after enactment.

Efficiency in Delegated Review (Section 845)

Title VIII provides for PSRO's to delegate their review functions to utilization review committees of hospitals, but only when the utilization committee demonstrates its capacity to carry out the required activities effectively, efficiently, and in timely fashion.

Under present law, PSRO's consider only effectiveness and timeliness of review in making delegation decisions. The Committee is concerned that, although hospital utilization review committees may be able to demonstrate effectiveness and timeliness, they may not in all cases be able to undertake these review activities as economically (on a cost per review basis) as the PSRO serving that hospital's area. Where this is the case, the Committee intends that the PSRO undertake the review activities. Accordingly, the Committee has added "efficiently" to the standards that a hospital utilization review committee must meet in order to continue to conduct delegated reviews.

When the PSRO law was enacted, PSRO's were not responsible for delegated hospital review budgets. Currently, however, PSRO's are limited in how much they can spend on review and PSRO's must negotiate review budgets with delegated hospitals. Although PSRO's have been negotiating lower unit cost rates with hospitals, based on hospital financial reports fiscal intermediaries can reimburse hospitals at higher rates than those negotiated. Delegated hospitals therefore have little incentive to hold their expenditures to the negotiated level. The only option available to PSRO's interested in withdrawing delegation to control costs is to demonstrate that the delegated review had been ineffective.

This section is effective on enactment.

Required Activities of Professional Standards Review Organizations (Section 846)

Title VIII provides that, in order to obtain full designation, a conditionally designated PSRO must, at a minimum, satisfactorily conduct reviews of routine inpatient health care services provided to medicare or medicaid beneficiaries by or in hospitals in its area. Title VIII eliminates the requirement of current law that a PSRO must review long-term care services in order to be fully designated and must, if capable, review ambulatory care services within two years of becoming fully designated. In addition, Title VIII directs the Secretary to establish a program for the evaluation of the cost-effectiveness of review of particular health care services by PSRO's, and to require PSRO's to conduct review of additional health care services (except as part of the evaluation program) only where such review has been found to be cost-effective or yields other significant benefits. Finally, Title VIII authorizes the Secretary of HHS to designate another qualified PSRO to conduct reviews of particular services not yet being performed by designated PSRO's.

Under present law, each PSRO is required to assume review responsibility for care (including physicians' services) delivered by or in all types of institutions within four years of receiving conditional designation. The law further permits an extension for two additional years of a conditionally designated PSRO's trial period if failure to implement reviews in all types of institutions is due to causes beyond the PSRO's control. Within two years of receiving full designation, how-

ever, the Secretary must require those PSRO's with the capability to review ambulatory care services to assume this responsibility.

The Committee generally favors the expansion of PSRO review activities into areas other than routine inpatient hospital services. The Committee recognizes, however, that the expansion contemplated by current law would be premature in the absence of evidence that expanded review would be cost-effective or would offer other significant benefits. Accordingly, Title VIII requires the Secretary to establish an evaluation program to determine whether long term, ambulatory, and ancillary care reviews are cost-effective. In designing the evaluation program, the Secretary is directed to ensure that a statistically valid method is used to choose which PSRO's will and will not be required to implement the particular type of review being evaluated. Any statistically valid method should have at least the following characteristics:

—The creation of an "experimental" group of PSRO's that implement the new review activity, and a "control" group of PSRO's that do not implement the new activity;

—The selection of the experimental and control groups in such a way as to maximize the similarity between the two groups in the period before the experimental group implements the new activity; and

—The selection of the experimental and control groups in a way which permits a comparison that is, in the statistical sense, unbiased.

The Committee recognizes that studying the utilization of health care services is a very complex undertaking and it is often difficult to make definitive determinations regarding cause and effect in this area. The Committee further recognizes that it will be difficult to design a statistically valid study because of the many factors which can affect utilization and quality practices and any resulting changes in these practices. The Committee, however, encourages the Secretary to control as many extraneous factors as possible in studying PSRO impact in the long-term and ambulatory care settings and on ancillary services. The Committee further recognizes that studies reported in the professional literature, or other evaluations, may also be used in determining whether review of particular health services is cost-effective or yields other significant benefits if such studies or evaluations are of comparable reliability to the studies required under the evaluation program.

These new requirements reflect the concern of the Committee that the effectiveness of PSRO review activities must be demonstrated more persuasively than has been possible in the past. Evaluations carried out to date by the Health Care Financing Administration and by the Congressional Budget Office of PSRO review of admissions and lengths of stay in acute-care hospitals suggest that such review may reduce utilization. The CBO has also concluded that the net savings generated by the PSRO program are less than program costs, whereas the Health Care Financing Administration evaluations have concluded that the program is cost-effective. Both the CBO and HCFA estimates, however, are based on controversial assumptions and are open to considerable error. Title VIII is designed to address this problem by mandating that valid evaluations be carried out before PSRO review of new services is generally required.

Based on a study outcome that PSRO review is cost effective or yields other significant benefits, the Secretary could require PSRO's to implement those types of review addressed in the study. Examples of other significant benefits that might be identified, and would justify requiring PSRO implementation of these types of review, would be demonstrated positive impacts on the quality of patient care, shifts in utilization to appropriate care settings, or reductions in the use of inappropriate treatment or services.

It is the Committee's intention that PSRO's which are now doing additional kinds of review which on their own initiative request to implement ancillary, long-term, or ambulatory care review, should be funded. The Committee feels that such funding should be continued and encouraged to enable PSRO's to carry out types of review directed at particular problems in their areas or to reward PSRO's which have demonstrated positive performance in the area of hospital review. However, prior to the completion of the study, the Secretary cannot require a PSRO to conduct a type of review it is not currently conducting if the PSRO does not want to initiate that particular type of review (unless it is necessary in order to obtain the data base needed for evaluation). If the evaluation study finds that a particular type of review is cost-effective or yields other significant benefits, the Secretary can then require other PSRO's to conduct such review.

In cases where the Secretary has determined that reviews of a particular service are cost-effective or yield other significant benefits but the PSRO for the designated area does not have the capacity to undertake such additional review, Title VIII authorizes the Secretary to grant another qualified PSRO (in reasonable proximity to the providers and practitioners whose services are to be reviewed) to assume that authority and responsibility until the first PSRO has acquired the capacity to undertake such reviews.

This section is effective on enactment.

Response of Professional Standards Review Organizations to Freedom of Information Act Requests (Section 847)

Title VIII provides that no PSRO will be required to make available any records pursuant to a request under the Freedom of Information Act until 180 days after the entry of a final court order requiring such disclosure.

Under current law, information and data collected and generated by PSRO's in the course of their review activities are, as a general rule, confidential. There are, however, several exceptions that permit disclosure of certain types of information to various persons or agencies for various purposes. For example, PSRO's are required to provide information to Federal and State fraud and abuse agencies to assist them in their investigative work. PSRO's are also required to make information available to State and local health planning agencies to assist them in carrying out health planning and related activities. The Department of Health and Human Services is now in the process of implementing these various statutory requirements by regulation. See 44 *Fed. Reg.* 3058 (Jan. 15, 1979).

Recently, a U.S. District Court ruled that some of the data held by PSRO's concerning patterns of practice of individual institutions and individual practitioners participating in medicare and medicaid

were subject to disclosure under the Freedom of Information Act. *Public Citizen Health Research Group* v. *Department of HEW*, C.A. No. 77-2093 (D.D.C., Sept. 25, 1979). None of the data sought in this litigation would identify individual patients or disclose their medical records. The Court stayed its order requiring release of the information at issue pending appeal, which has been taken.

This litigation has given rise to great concern among PSRO's and the medical community in general. There is considerable uncertainty as to what PSRO information will be disclosable, to whom, and under what circumstances. A resolution of these complex and competing considerations is clearly needed, so that all interested parties—PSRO's, physicians, program beneficiaries, other consumers, health planning agencies, fraud and abuse agencies, State medicaid agencies, State licensure boards, State rate-setting agencies, and health and medical researchers—will know how PSRO data are to be treated.

Toward this end, Title VIII includes a provision to assure that no PSRO could be required to disclose any data or information pursuant to a Freedom of Information Act request until 180 days following the conclusion of the appeal and the entry of a final order in the *Public Citizen* case. This provision is not intended to make moot or otherwise reflect Congressional intent with respect to the decision in the appeal of this case or related cases. The Committee desires the benefit of full judicial consideration of the issues raised by that litigation while at the same time assuring Congress the opportunity to review the propriety of disclosure of whatever data is ultimately ordered released. In addition, the Committee expects that the Department of HHS will expedite its development of a disclosure policy under current law, so that the Congress will have the benefit of the Department's final views on these issues as well. Finally, this provision will also give the Congress time to study the recommendations of the National Academy of Sciences, which has agreed to undertake a study of the issues raised by this litigation. This provision is not intended to bar, or in any way restrict, access to PSRO data as provided under section 1166 of the Social Security Act, section 1513(d) of the Public Health Service Act, or regulations implementing these sections.

This section is effective on enactment.

Consultation by Professional Standards Review Organizations With Health Care Practitioners (Section 848)

In lieu of the present requirement of formal advisory groups of health care practitioners to individual PSRO's, Title VIII authorizes the Secretary of HHS to establish more flexible guidelines to assure appropriate operational PSRO consultation with representatives of all health care disciplines on the performance of review activities.

Present law requires that advisory groups to PSRO's must be established and must be composed of not less than seven or more than eleven members who are representatives of health care practitioners other than physicians. Such formal advisory groups, however, have proved to be cumbersome and not totally effective in assuring appropriate consultation on operational matters. The Committee believes that more effective and practical arrangements can be achieved by authorizing the Secretary to establish and apply flexible guidelines relating to

organizatonal relationships—including the range, frequency, and continuity of contacts—for assuring operational PSRO consultation with all health care disciplines.

The Committee notes that its intention in providing more flexible authority to the Secretary is to allow the requirements for consultation with health care practitioners to be applied in a less burdensome manner than under current law. In specifying the frequency and manner of consultations, the Secretary is expected to set general standards rather than specific formal requirements, and to encourage appropriate consultation without establishing rigid and unreasonable conditions.

This section is effective 180 days after enactment.

Review of Routine Hospital Admission Services and Preoperative Hospital Stays by Professional Standards Review Organizations (Section 849)

Under Title VIII, PSRO's are authorized to focus preadmission review on those areas of relatively frequent overutilization—particularly routine hospital admission services and excessive preoperative stays—to assure that medicare and medicaid payments are made only when the routine tests and unusually long preoperative stays for elective conditions are medically appropriate. The Secretary also is granted the authority to direct a PSRO to conduct such reviews where the Secretary determines such reviews should be made on a timely cost-effective basis.

Present program policies direct PSRO's to review the appropriateness of hospital services received by medicare and medicaid patients. This review has been limited largely to a review of the need for the patient to be admitted to the hospital and the appropriateness of the length of stay. However, a number of studies have demonstrated that unnecessary or avoidable utilization occurs with respect to certain hospital practices that may not have received sufficient attention by PSRO's, including: diagnostic tests routinely provided on admission without a physician's order; weekend elective admissions to hospitals which are not equipped or staffed to provide needed diagnostic services on weekends; and preoperative stays for elective procedures of more than one day without justification for the additional days. Consequently, the Committee believes that PSRO's should have the clear authority (on their own motion or at the request of the Secretary to undertake preadmission reviews of these areas of overutilization so that payments are not made for medically unnecessary routine hospital services or preoperative days. As part of this authority, it is intended that PSRO's be able to look carefully at surgical procedures to determine which might be appropriately performed on ambulatory basis in a hospital outpatient department, an ambulatory surgical center or a properly equipped physician's office.

This section is effective on enactment.

Study of PSRO Norms, Standards and Criteria (Section 850)

Title VIII requires the Secretary of HHS to conduct, in consultation with the National Professional Standards Review Council, a nationwide study of the differences in PSRO's medical criteria and length-

of-stay norms. The Secretary is required to report the findings of this study to the Congress within one year of enactment.

Present law requires PSRO's to use professionally developed norms of care based on typical patterns of practice in their areas, and also requires the National Council to exercise oversight and approval over PSRO norms which are significantly different from professionally developed regional norms.

The Committee believes that basing PSRO criteria and norms exclusively on typical practice patterns in the area may serve to perpetuate the status quo, including whatever inappropriate practices may be present in the area. While there are legitimate reasons for some variations in medical criteria and norms from area to area, there is also substantial evidence of widely different criteria and norms for similar patients under similar conditions. For example, the typical length of stay for a gall bladder removal varies by as much as 6 days in different sections of the United States. The intent of the study provided in Title VIII is to determine what basis there is for such differences, so that the Congress can ascertain whether some steps should be taken to avoid the perpetuation of inefficiences.

The section is effective on enactment.

Nonprofit Hospital Philanthropy (Section 851)

Title VIII provides that, in determining the amount of reimbursement for nonprofit hospitals under the medicare, medicaid, and maternal and child health (Title V of the Social Security Act) programs, the following items are not to be deducted from operating costs: (a) unrestricted grants, gifts, and income from endowments; (b) donor-designated or restricted grants, gifts, or income from endowment; (c) unrestricted grants or gifts, or income therefrom, designated by the hospital's governing board as unavailable for operating funds; (d) governmental grants that are not available for use as operating funds; (e) sale or mortgage of real estate or other capital assets acquired through gift or grant that are unavailable for use as operating funds (except gains and losses realized from the disposal of depreciable assets); and sinking funds established exclusively to make payments to third parties for financing capital improvements.

Under present law, grants, gifts, and endowment income designated by the donor to pay for specific operating costs are deducted from those costs in determining the reasonable costs of services for purposes of reimbursement under medicare, medicaid, and the maternal and child health programs. Concern has been expressed that this policy may discourage philanthropic contributions to nonprofit hospitals for specific operating costs. The Committee believes that philanthropic support for health care should be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system. Accordingly, Title VIII provides that grants, gifts, and income from endowment whether restricted by the donor or not, are not to be deducted from operating costs in determining the level of reimbursement under the Federal payment programs.

This section applies to grants, gifts, and endowments made or established on or after September 1, 1981.

Consultative Services for Skilled Nursing Facilities (Section 852)

Under Title VIII, the provision of present law which authorizes medicare reimbursement for consultative services furnished by State agencies to skilled nursing facilities is repealed.

Under present law, the State agency responsible for determining skilled nursing facility compliance with medicare conditions of participation may furnish specialized consultative services, at the request of the facility, to help it achieve or maintain compliance with the conditions. However, since there have been no requests under this provision for medicare funding of consultative services, it is apparent that the provision is unnecessary. Moreover, the Committee believes that adequate provision has been made under the medicaid program for furnishing consultation to any skilled nursing facilities that might require such services.

This section is effective on enactment.

Study of Need for Dual Participation of Skilled Nursing Facilities (Section 853)

Title VIII requires the Secretary of HHS to conduct a study of the causes for the present scarcity of skilled nursing home beds, including the extent to which existing laws and regulations (as well as other factors) discourage dual participation of skilled nursing facilities in the medicare and medicaid programs, and report the results of the study to Congress within one year after enactment.

Under present law, skilled nursing facilities are not required to participate in both the medicare and medicaid programs. As a result, there are a number of areas of the country in which there are fewer beds available, either for medicare or medicaid beneficiaries, than might otherwise be the case if all skilled nursing facilities participated in both programs. While there are many opinions as to why a large number of facilities choose not to participate in both programs, the Committee believes there is little documentation and objective analysis of the reasons for this situation. To eliminate this gap in knowledge, Title VIII directs the Secretary to conduct a thorough study of the situation and assess the feasibility and potential consequences of requiring dual participation. In conducting the study, the Secretary is required to consult with professional organizations, private insurers, nursing home providers and consumers of skilled nursing services, and is required to submit a report on the results of the study together with any recommendations for legislative changes.

This section is effective on enactment.

Alternative to Decertification of Long-Term Care Facilities Out of Compliance With Conditions of Participation; Look Behind Authority (Section 854)

Title VIII authorizes the Secretary of HHS and State medicaid agencies to deny reimbursement for services furnished by a skilled nursing facility (SNF) or an intermediate care facility (ICF) for all medicare and medicaid beneficiaries admitted to the facility after the

date the Secretary determines that such facility is substantially out of compliance with the conditions of, or requirements for, participation. In the case of a facility with deficiencies that immediately jeopardize the health and safety of its patients, title VIII requires the Secretary and the State agency to decertify the facility, and while decertification is underway, to deny reimbursement for medicare and medicaid patients admitted subsequent to the determination of noncompliance. In addition, Title VIII authorizes the Secretary to "look behind" a State's survey of an SNF or ICF and, where the Secretary finds that a facility does not meet the conditions of, or requirements for, participation, to terminate the participation of the facility in medicare and medicaid.

At present, the only sanction available in many jurisdictions to penalize a skilled nursing facility which is out of compliance with the conditions of participation in the medicare and medicaid programs is to terminate that facility's participation in the program. Frequently, this sanction involves an overriding hardship to program beneficiaries which makes its use undesirable, if not impossible.

In the case of facilities that are substantially out of compliance but do not have deficiencies that immediately jeopardize the health and safety of their patients, Title VIII gives the Secretary authority to impose an intermediate sanction, short of the more drastic step of program termination. The Secretary is expected to define by regulation the grounds for the imposition of an intermediate sanction. It is the expectation of the Committee that the existence of sanctionable deficiencies with the conditions of participation will generally be determined during the course of the formal State survey of the facility or HHS compliance validation surveys. The denial of reimbursement for services furnished to medicare or medicaid beneficiaries admitted after a date designated by the Secretary is to continue until such time as the deficiencies have been corrected or it is determined that good faith efforts to correct deficiencies are being made. This alternative sanction is applicable for a limited period, not to exceed 12 months; thereafter, Title VIII requires the Secretary to decertify the facility.

In the case of facilities that are substantially out of compliance but have deficiencies that immediately jeopardize the health and safety of the patients, Title VIII directs the Secretary or State agency to decertify the facility and, while the decertification process is underway, to deny reimbursement for any services furnished to medicare or medicaid beneficiaries admitted after a designated date. This additional sanction is applicable for the duration of the decertification or termination proceeding.

Under Title VIII, a facility is to have an opportunity to develop and implement a plan for correcting its deficiencies, in accordance with existing medicare policies on the correction of provider deficiencies. Following the facility's failure to satisfactorily meet this requirement, the Secretary can apply intermediate sanctions, but only after the Secretary has provided the facility with an opportunity to present its case at an informal hearing consistent with current practices. If the facility seeks further administrative or judicial appeals, the sanction is to remain in effect while the appeals are pending.

(It should be noted that it is not the intention of the Committee that a decision to impose sanctions shall preclude whatever right to judicial

review of disputes of fact concerning noncompliance with conditions of participation which a facility otherwise has.)

The Secretary is required to provide public notification to potentially affected beneficiaries of the effective date of the sanction and the fact that no benefits will be payable on behalf of a beneficiary admitted to the facility after that date. (Benefits are to continue to be paid on behalf of beneficiaries who were inpatients of the facility prior to the designated date.) The Secretary is required to promulgate regulations setting forth the procedures for implementing this provision of Title VIII.

The Committee believes that the application of this sanction, in lieu of immediate decertification of a facility where life and safety are not threatened, will serve to protect beneficiaries both by giving the skilled nursing facility an incentive to correct deficiencies in a timely manner and by forestalling the need for traumatic transfers of large number of patients during the time needed improvements are being made in the facility. However, the Committee believes that this sanction should not be used as an alternative in situations where a noncomplying facility's deficiencies place the health and safety of its patients in immediate jeopardy; instead, the response of the Secretary in such cases must be to deny all reimbursement for additional patients and to make appropriate arrangements for the orderly, planned transfer of existing patients.

The Committee recognizes that several States presently have a full range of intermediate sanctions available, as part of their licensure authority, to impose against noncompliance facilities, including suspension of payments, bans on admissions, or even fines and penalties. Title VIII is not intended to limit or preempt such authority.

Title VIII further authorizes the Secretary to make an independent and binding determination concerning the extent to which SNFs and ICFs that participate only in medicaid meet the requirements of participation in that program, and to terminate the eligibility of any facility that the Secretary finds does not comply with such requirements.

This section is effective on enactment.

Life Safety Code Requirements (Section 855)

Title VIII authorizes the Secretary of HHS to determine in regulations when skilled nursing facilities participating in medicare and medicaid are to be required to meet the provision of revised editions of the Life Safety Code.

This provision of Title VIII repeals the requirement of present law that a skilled nursing facility must meet the 1973 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) and allows the Secretary to establish the time frame for application of the latest edition of the Code. Since the Life Safety Code is revised by the NFPA approximately every 3 years to accommodate changes in technology or philosophy, the statutory requirement that facilities meet a specified edition of the Code creates unnecessary administrative complications and burdens on providers. Although a 1976 Code is currently in general use and a 1980 Code is under development, medicare and medicaid facilities are still required by law to comply with the 1973 edition of the Code. To eliminate this discrepancy and to permit the flexibility necessary to adjust to scientific

developments in the fire protection field, Title VIII allows the Secretary to revise the Life Safety Code requirement on a more timely basis without having to seek legislative changes. Moreover, such flexibility will reduce the regulatory burden on providers resulting from the application of unnecessary or out-of-date rules.

It is not the intent of Title VIII that the Secretary select among provisions from more than one edition of the Code in determining LSC requirements. Rather, one edition of the Code, in its entirety, is to be adopted. The Committee expects that normally the latest edition will be the one required. However, the Secretary is granted the authority to review each new edition of the Code to assure that its provisions continue to afford adequate protection for the health and safety of patients. The Secretary also is granted the authority to require adoption of a new edition of the Code within a reasonable time frame, consistent with the capabilities of the States to conduct the necessary surveys of facilities using the new edition of the Code. Moreover, Title VIII does not limit the Secretary's present authority to use, wherever appropriate, the equivalency standards developed by the National Bureau of Standards and incorporated by the NFPA as part of the Life Safety Code.

The Committee recognizes the potential for certain problems arising as a result of revisions embodied in later editions of the Code that may upset structural accommodations previously made by providers at some cost to them. The Committee expects the Secretary to be fully cognizant to the impact of such changes on providers and to take them into account in revising the Life Safety Code requirement. The intent of the change made by Title VIII is to minimize regulatory burdens on facilities, consistent with protection of the health and safety of patients and to assure orderly adjustments to changing technology.

This section is effective on enactment.

Criminal Standards for Certain Medicare- and Medicaid-Related Crimes (Section 856)

Title VIII provides that criminal penalties for solicitation or payment of kickbacks, bribes, rebates, or other remuneration in exchange for medicare or medicaid business apply only in cases where such conduct is undertaken knowingly and willfully.

Under present law, the solicitation or receipt of any remuneration in return for referring a medicare or medicaid patient to another party or in return for purchasing, leasing or ordering any service or supply covered under medicare or medicaid constitutes a felony, punishable by a fine of up to $25,000 or 5 years imprisonment, or both. The offer or payment of kickbacks, bribes, or rebates for such purposes is also a felony, punishable to the same extent. The Committee is concerned that criminal penalties may be imposed under current law to an individual whose conduct, while improper, was inadvertent. Accordingly, Title VIII clarifies present law to assure that only persons who knowingly and willfully engage in the proscribed conduct are to be subject to criminal sanctions.

This section is effective on enactment.

Exclusion of Health Care Professionals Convicted of Medicare- or Medicaid-Related Crimes (Section 857)

Under Title VIII, the provisions of present law relating to the exclusion from participation in the medicare and medicaid programs of physicians and other practitoners convicted of program-related crimes is broadened so as to apply to other categories of health professionals, such as administrators of health care institutions.

Under present law, medicare and medicaid payment may be denied for goods and services furnished by a physician or other practitioner convicted of a program-related crime. However, similar action cannot now be taken with respect to other health professionals (such as operators or administrators of health care facilities) who are convicted of program-related crimes. Title VIII rectifies this deficiency in the law. In the case of those professionals who do not directly furnish medical care or services, payment is not to be made to the provider for the cost of any services furnished to or on behalf of the provider by the convicted professional in connection with either program. (The provision of present law relating to a right to a hearing on a determination of the Secretary of HHS to bar an individual from participation is retained.) Title VIII also clarifies the intent of present law that the Secretary is authorized to bar a professional who may have participated only in the medical or medicare program from participation in both programs.

This section is effective on enactment.

Requirements Concerning Reporting of Financial Interest (Section 858)

The requirements of present law relating to the reporting of financial interests as a condition of participation in medicare and medicaid are amended by Title VIII to provide that an entity is required to report only those individual interests in mortgages or other obligations equal to at least $25,000 or 5 percent of the entity's total assets. Present law requires the reporting of all interests of 5 percent or more of any such obligation secured by property of the reporting entity, even where the obligation is secured by a small portion of the entity's assets.

Title VIII also clarifies the States' responsibility to require compliance with the disclosure requirements of present law as a condition of participation in the medicaid program.

This section is effective on enactment.

Withholding of Federal Share of Payments to Medicaid Providers To Recover Medicare Overpayments (Section 859)

The authority of the Secretary of HHS under present law to recover overpayments under medicare, where a provider has withdrawn or has been terminated, by withholding the Federal share of medicaid payments to the provider is extended by Title VIII to instances where: (a) the provider continues to participate in medicare but at such a minimal level as to preclude recovery of the overpayment; and (b) where recovery of large medicare overpayments under part B to a physician or other health professional is precluded because the prac-

titioner or professional is not participating in medicare (i.e., no longer accepts assignment for medicare claims).

Under present law, the Secretary can withhold the Federal share of medicaid payments from providers in order to recover medicare overpayments, but only where the provider has withdrawn or has been terminated from participation in the program. The purpose of this provision of Title VIII is to prevent such a provider from circumventing the intent of the recovery provisions of present law by formally maintaining its status as a patricipating medicare provider while substantially reducing its acceptance of medicare patients. Similarly, Title VIII permits recovery of medicare overpayments to physicians and professionals who subsequently elect not to accept assignment for medicare claims and thus, preclude any recoupment of such overpayments through offsets against future medicare payments.

The Committee notes that it is not the intent of this section or the recovery provisions of present law to penalize State medicaid programs by making them absorb the full cost of medicaid payments to these medicare providers who received overpayments under title XVIII of the Social Security Act. The Committee expects that the Secretary will provide adequate advance notice of no less than 60 days to the State concerning the providers who would be subject to the procedures for recovery of medicare overpayments through the withholding of the Federal share of the medicaid payment, so that the State will have sufficient opportunity to change its payment procedures to these providers to insure that the reimbursement is limited only to the State share of the bill.

This section is effective on enactment.

Hospitals Providing Long-Term Care Services "Swing Beds" (Section 860)

Title VIII authorizes the Secretary of HHS to enter into agreements with certain hospitals, for purposes of reimbursement under the medicare and medicaid programs, under which the hospital can use its beds on a "swing" basis as either acute or long-term care beds, depending on need. A simplified cost reimbursement formula would avoid the current requirement for separate patient placement within the hospital and separate cost finding. (This formula would also reflect the lower cost of providing less than acute care.) Hospitals which have been granted a certificate of need for the provision of long-term care services are to be eligible to enter into such agreements.

Where a hospital does not have such an agreement, payment for long-term care services furnished to a beneficiary who remains in the hospital because no long-term care beds are available in the community is to be made at the average medicaid skilled nursing or intermediate care facility rate (as may be appropriate) if the hospital's average annual occupancy rate is below 80 percent and the hospital can obtain a certificate of need to provide long-term care services.

Patient days of care that are paid by medicare at the reduced rate are to be counted against the beneficiary's eligibility for skilled nursing facility benefits. Similarly, the medicare skilled nursing facility benefit coinsurance rates are to be applicable.

The Committee believes that a number of hospitals in areas where there is a scarcity of long-term beds could use their unoccupied acute care beds to provide a less intensive level of care. Under present law, however, such a lesser level of care furnished to medicare and medicaid patients in hospitals is not appropriately covered unless furnished in a distinct part of the hospital where beds are reserved solely for nursing care patients. Title VIII allows such hospitals to use their acute care beds to provide nursing care services which would otherwise be covered under medicare or medicaid if the services were provided in a skilled nursing or intermediate care facility. In order to assure the quality and appropriate use of such services, nursing care services provided to medicare and medicaid beneficiaries in such a hospital are to be subject to certain skilled nursing facility conditions of participation relating to social service staffing and functions and discharge planning that are not treated as specifically in the hospital conditions of participation. The conditions that the Committee expects the Secretary to apply include: (a) the social service provisions that require the facility to make an effort to identify the patient's social and emotional needs and to employ, or have a referral agreement with, a qualified social worker or social work agency; and (b) the requirement that the facility maintain an active discharge planning program. In addition, the Committee believes it would be desirable to encourage the facility's governing body to establish and direct the implementation of written policies regarding the rights of long-term care patients.

In order to avoid imposing a possible disadvantage on institutions that have established "distinct part" skilled nursing facilities, Title VIII provides that the simplified "swing-bed" method of reimbursement is to be made available under medicare and medicaid for services furnished in such "distinct part" facilities. The Secretary is to approve this alternative reimbursement method where the hospital demonstrates that its use will contribute significantly to efficient and effective administration and will be in the interest of program beneficiaries. Making the simplified reimbursement option available will put institutions with distinct part skilled nursing facilities on an even footing with the other hospitals that will be eligible for "swing-bed" reimbursement under Title VIII.

Where continued hospital stay in an institution that has not entered into a "swing-bed" agreement with the Secretary is necessitated by the unavailability of an appropriate long-term care bed in the community, and (i) the hospital's occupancy rate is below 80 percent and (ii) it could obtain a certificate of need, payment is to be made at the same rate otherwise payable to a participating "swing-bed" hospital. It is the Committee's intent that this second standard, i.e., that the institution could have obtained a certificate of need, will be considered met if the State Health Planning and Development Agency had found in its current State Health Plan that a shortage of nursing home beds existed in the area in which the hospital is located, or if the agency determined that long-term care beds were not available in the area in institutions which would agree to accept medicare and/or medicaid reimbursement. It is not the intention of the Committee that the hospital must receive from the planning agency a formal decision relating to its specific case. Similarly, it is not the intent that the Secretary be required to evaluate the local circumstances

to determine if a certificate of need would have been given under State law.

In determining the appropriate rate of reimbursement for hospital patients receiving long-term care services where no swing-bed arrangement exists, the intermediary in the case of medicare or the State medicaid agency is expected to determine on a case by case basis in accordance with standards established by the Secretary that no appropriate long-term care bed is available in an institution which will accept medicare and/or medicaid reimbursement. If it is determined that an appropriate long-term care bed is available, then the Committee expects that payment will not be made to the hospital for those patients needing only long-term care services (unless there was a swing-bed agreement or they were in a recognized distinct part). Further, the Committee notes that institutions which regularly receive payment for patients who do not need acute care but are receiving long-term care services in the hospital because no other bed is available in a skilled nursing facility should be encouraged to enter into a formal swing-bed arrangement.

If the hospital's occupancy rate is 80 percent or above, or it cannot obtain a certificate of need, payment is to be made, as under present law, at the hospital rate for such period as it is medically determined the patient requires covered skilled nursing services and an appropriate bed is temporarily unavailable.

In adopting these provisions, it is the intent of the Committee both to allow a more flexible situation for hopsitals providing long-term care services when beds are not available in long-term care facilities and to reduce unnecessary expenditures at an acute care rate for hospital patients who are receiving only long-term care services. It is the Committee's intent that medicaid payments for such patients are to also be reduced to the "swing-bed" rate. In past court cases, decisions have been rendered requiring States to continue to reimburse at the acute care rate for patients in hospitals receiving only SNF services because no bed was available in a skilled nursing facility. At that time, the only reimbursement options were to pay the hospital rate or not pay at all. This provision of Title VIII is designed to provide States the more reasonable standard of paying at the swing-bed rate, paralleling the medicare procedure.

The amendments made by this section are effective on the date final regulations are issued, and such regulations are to be issued no later than the first day of the sixth calendar month following the month of enactment.

Coordinated Audits Under the Social Security Act (Section 861)

Title VIII requires common audits of entities reimbursed on a cost-related basis under titles V (maternal and child health), XVIII (medicare), and XIX (medicaid), of the Social Security Act. Title VIII of this bill also requires the Secretary of HHS to undertake one or more demonstration projects with respect to such entities to determine the feasibility of a single coordinated appeal hearing to adjudicate disputed administrative cost items.

Currently, these programs generally provide for reimbursement of participating health care facilities on a reasonable cost or cost-related

basis. To assure that payment of reasonable cost is achieved, a comprehensive provider audit program has been established. The medicare audits are mandated by law; the medicaid audits are required by regulation. At the present time, unless covered by a common audit agreement, providers have a separate audit conducted for medicare and medicaid. The duplicate auditing effort can be costly and time-consuming.

A voluntary common provider audit was established in 1968 by the Department of Health, Education and Welfare which established procedures to be followed, costs to be shared, method of payment for services and what coordination was necessary. Under the voluntary program, 37 States contracted with intermediaries for coordinated audits for some or all medicare-medicaid providers. Over half of the hospitals participating in medicare were covered by those agreements. Under recently revised procedures authorizing freer exchange of audit information between the programs, all States have been negotiating new coordinated audit agreements with medicare intermediaries.

Under the new agreements, medicare will supply all of its audit information to the States free of charge. States will pay only the incremental costs to medicare intermediaries for auditing activities required solely for medicaid purposes. The Committee expects the Secretary to continue to follow this way of allocating costs when common audits are required.

Duplication of identical or similar auditing procedures used for the purpose of determining reimbursement under various Federal programs is costly to both the programs and the entities participating in the programs. In order to eliminate this duplication, Title VIII of this bill requires that, if an entity provides services reimbursable on a cost-related basis under Titles V or XIX, audits of books, accounts, and records of that entity are to be coordinated through common audit procedures with audits performed for the purpose of reimbursement under Title XVIII. Where a State declines to participate in such common audits, the Secretary is to reduce payments that would have been made to the State under the Titles V or XIX by any amount in excess of the amount that would have been apportioned to the State if it had participated in the audit.

Duplication of procedures for hearing and adjudicating appeals from audit findings may also be unnecessarily burdensome and costly. Title VIII directs the Secretary to establish one or more demonstration projects to determine the feasibility of linking a common audit with a single coordinated appeal procedure.

This section is effective on enactment.

Demonstration Projects Relating to the Training of AFDC Recipients as Home Health Aides (Section 862)

Title VIII authorizes the Secretary of HHS to enter into agreements with up to 12 States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of AFDC recipients as homemakers and home health aides. Ninety percent Federal matching is to be provided under the States' medicaid programs for the reasonable costs (less any related fees collected) of conducting the projects. The projects are to be limited to a maximum

of 4 years plus an additional period of up to 6 months for planning and development and a similar period for final evaluation and reporting. The Secretary is required to submit annual evaluation reports, and a final report on all the projects, to the Congress.

It has been estimated that as many as 40 percent of the aged and disabled now in high cost nursing care facilities do not necessarily have to be there—and would probably not be there if alternative supportive services to maintain them in their own homes were available. At the same time, there are many persons currently on the welfare rolls who, if they received appropriate training, could become gainfully employed members of ancillary health professions. The Committee's intent is to permit the Secretary to undertake several demonstration projects to assess the validity of these assumptions and the potential savings to the medicare and medicaid programs of reduced use of institutional care.

A State participating in the project is required to establish a formal program, approved by the Secretary, to train participants in the provision of homemaker and home health aide services. The State is to provide for the employment of those who complete the training program with public or (by contract) nonprofit private agencies engaged in furnishing such services on a part-time or intermittent basis to aged, disabled or other incapacitated individuals who in the absence of such services might otherwise require institutional care.

AFDC recipients entering such a training program are to be considered to be participating in a work incentive program authorized under part C of Title VI of the Social Security Act. During the first year such an individual is employed under the program, he or she will retain medicaid eligibility and any eligibility he or she had prior to entering the training program for social and supportive services provided under part A of Title IV. Federal funding is not to be available for the employment of any participant under the project after the participant has been employed for a 3-year period.

This section is effective on enactment.

Quality Assurance Programs for Clinical Laboratories (Section 863)

Title VIII extends to December 31, 1980, the authority of the Secretary of HHS to conduct a program to determine the proficiency of health care personnel, including clinical laboratory personnel, who do not meet formal educational requirements.

The Committee believes that proficiency examinations represent an effective mechanism for identifying competent health personnel who may lack the necessary credentials otherwise required under personnel standards contained in medicare's conditions of participation.

This section is effective on enactment.

Reimbursement of Clinical Laboratories Under Medicare and Medicaid (Section 864)

Title VIII places limitations on reimbursement for markups on clinical laboratory services billed by physicians under medicare and medicaid and authorizes State medicaid agencies, on a demonstration

basis, to purchase laboratory services through a competitive bidding process. Title VIII further directs the Secretary of HHS to evaluate and report to Congress on the impact of these policy changes. Title VIII also clarifies the requirement that all clinical laboratories furnishing services for which payment is claimed under medicaid must meet the medicare standards for participation.

Under current law, the medicare and medicaid programs may make payment for clinical laboratory services to hospitals, to physicians, or directly to independent laboratories; medicare can also make payments directly to patients. When the payment is to the physician, it may be for a test performed in his office, or it may be for a test which he sent out to an independent laboratory, which then billed the physician for the work. There is evidence, documented in GAO reports, that in some cases, the physician bills the patient (or the medicare or medicaid programs) for the test that was performed by the independent laboratory at rates greatly in excess of what the laboratory charged the physician for the work.

Title VIII addresses this problem of substantial markups of bills for laboratory services where the bill is submitted by the physician but the laboratory services are not performed by him. Title VIII provides that when a physician includes an amount in his bill for laboratory services, he must indicate either (i) that he or another physician in his office personally performed or supervised the laboratory services or (ii) the name of the laboratory performing the services and the amount the physician was billed by the laboratory.

If the physician fails to provide the necessary information, the payment allowed for the laboratory services included in his bill will be limited to the charge estimated by the medicare carrier to be the lowest charge at which the services could have been secured by a physician from a laboratory serving the applicable locality. This provision is designed to serve as an incentive to the physician to provide the necessary information on laboratory services included in his bill, so that it can be determined that the laboratory doing the work is one that meets appropriate standards, and so that the program administrators can be certain that there is no unreasonable markup in the charge. Under current program requirements, physicians are required to provide similar information, but often do not. Medicare carriers find it impossible to follow up on all bills where the information is not included. This provision provides authority to limit payments in these situations.

If the physician indicates on his bill that the laboratory service was performed elsewhere, and indicates which laboratory performed the service and how much they billed him, the allowed payment will be the lower of that laboratory's reasonable charge (subject to the usual requirements of the law for determining reasonable charge) or the amount actually billed the physician, plus a nominal fee to cover the physician's costs in collecting and handling the sample. The Committee intends this fee to be limited to the minimum amount generally necessary to cover physicians' actual costs of collecting and handling samples on which tests are performed.

The Committee expects this provision to result in lower program payments in many instances, because it is not uncommon for a labora-

tory to bill a physician less than its reasonable charges. This provision will assure that the program will benefit from the discounted rate.

If the physician's bill indicates the laboratory service was performed by the physician or another physician with whom he shares his practice, or by someone under their supervision, the reimbursement allowed is to be the physician's reasonable charge for that service (again, subject to the applicable provisions of the law regarding reasonable charge). The Committee notes that use of the phrases "supervised the performance of such services" or "supervised such services" does not require that a physician personally supervise the performance of each test for which a bill has been submitted. The physician is expected to exercise genera supervisory responsibility. (In all cases, the amounts reimbursable u ider medicare are subject to applicable deductible and coinsurance requirements.)

While the Committee has determined that these limitations on payments for laboratory services are appropriate, there is concern that the reduction in reimbursements may fall on the patient rather than on the physician who fails to provide the required information on the laboratory services or who is engaging in excessive markups. The structure of the medicare program, under which many physicians do not take assignment and bill the program directly, results in many patients paying the physicians' fees and then submitting the bill to medicare. In this situation, there is a potential for the patient rather than the physician to feel the effect of the medicare policy to limit payments for laboratory services. The Committee has determined that there cannot be justification for continuing a policy of paying excessive markups on laboratory tests because the failure of physicians to take assignment might result in the lower reimbursement going to the patient rather than the physician. However, the Committee has directed the Secretary to report to the Congress within 2 years on the experience with this provision, particularly in regard to how frequently the reduction in the allowed amount has resulted in lower payments to the patient rather than to the physician. This information will allow determination of whether further legislative change to protect the patient is necessary. Additionally, the Secretary is required to report on the savings in expenditures for laboratory services which have resulted from this provision.

Under the medicaid program, a State has the authority to require that all bills for laboratory services be submitted directly by the practitioner or entity performing the service. Title VIII leaves that option to the States; however, if a State opts instead to allow indirect billing, it is required to assure that reimbursement does not exceed the amount that would be allowed under medicare. To assure this, a State will have to require the physician to submit information essentially similar to the information required by medicare.

Under current medicaid law, program eligibles are entitled to obtain covered services from the provider of their choice. This freedom of choice requirement poses a bar to State or local efforts to limit the number of clinical laboratory service providers participating in medicaid through a competitive bidding process. However, the freedom-of-choice concept has little real applicability in the case of laboratory

services where the patient, in fact, does not "choose" his provider in any real sense. Further, the Committee notes that GAO has found that, even though medicaid programs are high volume purchasers of clinical laboratory services, States often pay higher prices for such services than other purchasers. Based on these findings, GAO recommended that competitive bidding for medicaid laboratory services be tried on an experimental basis.

Title VIII allows States (or parts thereof) to purchase laboratory services for a 3-year period under arrangements which are not to be subject to the general freedom of choice requirements of the medicaid law, provided that the Secretary approved the plan. The Secretary is to determine that services would be purchased only from laboratories that met standards, and that the prices charged the program do not exceed the lowest amount charged to others for similar tests, or, if the purchasing arrangements were agreed to on some unit price basis, that the aggregate expenditures do not exceed the aggregate expenditures that would have been anticipated if each test was charged at the lowest rate charged to others for that test. Additionally, the Secretary must be satisfied that under the arrangements, adequate laboratory services are available to the physicians and other providers treating medicaid patients. The Committee has required that the Secretary may approve State plans only when these conditions are met.

Finally, Title VIII clarifies the legislative authority for the current requirement in regulation, that medicaid laboratories must meet the same standards required for laboratories participating in the medicare program.

This section applies to medicare requests for payment and bills submitted on or after the date prescribed by the Secretary in regulations but not later than October 1, 1980.

Reimbursement of Physicians' Services in Teaching Hospitals (Section 865)

Title VIII continues to authorize reimbursement under medicare and medicaid to hospitals with approved teaching programs for services rendered by physicians if the hospital so elects and if all physicians agree not to bill program eligibles for professional services rendered in the hospital; otherwise, physicians in teaching hospitals are to be eligible for reimbursement directly under the physician payment provisions of medicare and medicaid. Title VIII also repeals certain provisions of the 1972 Amendments to the Social Security Act relating to payment of teaching physicians that were never implemented through regulations.

The medicare program is comprised of two complementary programs—the Hospital Insurance program which generally pays for institutionally provided services, such as hospital care, and the Supplementary Medical Insurance program which pays for physician, diagnostic, and ambulatory services. This structure raised several administrative questions when applied to the nation's teaching hospitals where the physicians provide both professional medical services to

individual patients and educational and supervisory services to the hospital itself. Essentially, the bipartite structure of the medicare program necessitated that the dual activities of these teaching physicians be clearly separated for reimbursement purposes between the Hospital Insurance and Supplementary Medical Insurance components of medicare. In the early years of the medicare program, this separation was not effectively accomplished in some teaching hospitals.

The Social Security Amendments of 1972 (Public Law 92–603) included a provision (section 227) which was intended to assure that medicare would make charge reimbursement for physician services furnished in teaching hospitals only if its beneficiaries received bona fide private patient care. This was believed to be necessary because the General Accounting Office and other investigators found that some teaching physicians billed for services actually furnished by interns or residents who assumed responsibility for the treatment; in other cases, physicians' charges were out of proportion to the physician services actually rendered or the charges billed to other patients. Section 227 generally treated physician services furnished in teaching hospitals as hospital services, reimbursable to the hospital on the basis of reasonable costs. However, two exceptions were permitted to this general rule: charges were payable for physician services furnished in certain hospitals which had traditionally billed and collected for physician services on a charge basis; charges were also payable if a hospital's patients were private patients, with "private patient" to be defined in regulations by the Secretary. Implementation was scheduled for hospital cost reporting periods beginning after June 30, 1973.

However, to date, implementation has not occurred. Initially, section 15 of Public Law 93–233 delayed implementation so that the Institute of Medicine of the National Academy of Sciences could study and report on reasonable and equitable methods of reimbursing for physician services in teaching hospitals. (Section 15 also provided that hospitals could elect cost reimbursement for their physicians' services if all the physicians in the hospital agreed not to bill charges for services furnished to medicare patients. A small number of teaching hospitals have elected to be paid for physician services on this cost basis.) The Institute of Medicine study was issued in March 1976. The changes proposed by section 227 were to have taken effect on October 1, 1978. However, the Secretary of HHS has still not issued a notice of proposed rulemaking to implement the section 227 changes.

The Committee believes that no purpose would be served by further postponement of the effective date. The current situation results in uncertainty for providers and physicians concerning what the standards for reimbursement will be. Further, the Committee has reluctantly concluded that the current provision is apparently unadministrable. Additionally, the Committee believes that there have been significant changes in the way services are furnished in teaching hospitals since enactment of section 227. Intermediary Letter No. 372, issued in April of 1969, established clearer criteria for identifying the personal, identifiable services a teaching physician must perform for an individual patient to qualify for a fee-for-service payment under the Supplementary Medical Insurance component of medicare. When these criteria

are not met and properly documented in the medical record, it is presumed that the physician has provided only educational or supervisory services, and the costs of the service are included in the reimbursement from the hospital component of medicare. The patient care requirements of Intermediary Letter No. 372 seem to have been accepted by teaching physicians and adopted as policy by teaching hospitals.

Title VIII, therefore, permits physicians to continue to be reimbursed on a charge basis, unless the teaching hospital and all its physicians elect to be paid on the basis of reasonable cost (as previously permitted by section 15 of Public Law 93–233 on an interim basis), with the understanding that as a minimum, the guidelines currently in effect governing payment for physicians' services in teaching hospitals, which the Committee endorses, will remain in effect. Further, the Committee expects that HHS will take steps forthwith to incorporate these guidelines in its regulations. Physicians, teaching hospitals, and related entities should recognize that the Committee's action is not an invitation to return to any abuses of the late sixties. The Committee strongly believes teaching physicians should personally perform or personally supervise patient services in order to qualify for fee-for-service payment. The Committee notes that failure of a physician, teaching hospital, or related entity to comply with these requirements constitutes, among other things, a false statement or misrepresentation of a material fact in an application of payment under medicaid or medicare. The Committee expects the Department and State medicaid fraud and abuse control units to vigorously pursue any noncompliance.

Where States elect to compensate for services of teaching or supervising physicians under medicaid, Federal matching is to be limited to payments not in excess of medicare allowances.

The provision is effective with cost reporting periods beginning on or after October 1, 1978.

Demonstration Projects for Requiring Second Opinions for Certain Elective Surgical Procedures Under Medicare and Medicaid; Application of Informed Consent to Certain Demonstration Projects (Section 866)

Title VIII authorizes the Secretary of HHS to undertake, through grant or contract, demonstration projects to determine the cost-effectiveness and effect on the patient of mandating that medicare and medicaid beneficiaries obtain a second opinion with respect to certain elective surgical procedures before payment will be made for those services.

Under present law, persons eligible for benefits under medicare and medicaid are entitled to have payment made for medically necessary physicians' and hospital services, including medically necessary elective surgical procedures. If program eligibles voluntarily seek second opinions from another physician before undergoing elective surgery, 100 percent reimbursement is made for those consultations, subject to applicable cost-sharing requirements.

The Committee believes that second opinion programs may be of great value in reducing unnecessary surgery, in reducing unnecessary expenditures (both by Government and consumer), and by enabling consumers of medical care to make better informed choices as to their own well-being.

Title VIII further provides that no medicare or medicaid beneficiary may be required to participate in a demonstration project for requiring second opinions for certain elective surgery without his or her informed consent.

Present law and current policy regarding reimbursement for second opinions will remain unchanged and will not be affected by Title VIII's provisions for second opinion demonstrations.

This section is effective for calendar quarters beginning on or after October 1, 1980.

Continued Use of Demonstration Project Reimbursement Systems (Section 867)

Title VIII authorizes States with rate-setting programs for the payment of hospital services that have been approved as demonstration projects by the Secretary of HHS to continue to determine medicare and medicaid reimbursement rates for hospitals under those programs unless the Secretary finds that the program no longer meets applicable standards.

Under present law, hospitals participating in medicare and medicaid are generally reimbursed on a "reasonable cost" basis for covered inpatient services. The Secretary has the authority to approve the use of alternative reimbursement rates or methodologies in connection with demonstration projects to determine whether the alternatives will increase the efficiency and reduce the cost of providing hospital services under medicare and medicaid without adversely affecting the quality of services provided. Four major projects in Maryland, New York, New Jersey, and Washington are currently operating under this demonstration authority.

While the Secretary has authority to determine the appropriate length of a demonstrating project sufficient to carry out the purposes of the demonstration, the Secretary does not have the authority to extend demonstration projects indefinitely. As a result, several States now operating approved programs are in jeopardy of losing their authority to determine medicare and medicaid rates for hospital services on other than a "reasonable cost" basis, even though the programs have effectively restrained the rates of increase in the costs of hospital services. The loss of this authority would have a severe and adverse impact on the ability of the affected States to carry out their hospital cost containment efforts and might lead to increased Federal medicare and medicaid outlays as well.

Title VIII requires the Secretary to continue to allow medicare and medicaid reimbursement to be made under a reimbursement system originally established on a demonstration project basis after the demonstration period has ended. The demonstration projects must have been approved by the Secretary under section 402 of the So-

cial Security Amendments of 1967 as amended by Section 222(b) of the Social Security Amendments of 1972, or Section 222(a) of the Social Security Amendments of 1972, and the rate of increase in the costs per admission of medicare patients during the course of the project must have been less than or equal to the rate of increase for all medicare beneficiaries during that period. If these conditions are met, and if the State has legislative authority to operate such a system (and the State elects to have reimbursement made under the system) or the system is operated through a voluntary agreement of hospitals (and those hospitals elect reimbursement under the system), then the Secretary must continue to allow medicare and medicaid rates to be established through the rate-setting system.

Under Title VIII, use of the demonstration project reimbursement system is to continue until the Secretary determines that all third party payers do not reimburse participating hospitals on the basis required under the system, or that the rate of increase in costs per admission of medicare patients in the participating hospitals when measured over the previous three year period, exceeds the comparable rate of increase in costs per admission for medicare patients in all hospitals throughout the country. These limitations on the State's continuing authority are intended to insure that the medicare program does not pay more for hospital services under the State's system than under the "reasonable cost" payment method.

The Committee expects the Secretary to develop a process for reviewing and validating the performance of the system, and for monitoring any changes in the plan. It is not the intent of the Committee to freeze the system in place in exactly the form approved as part of the demonstration if improvements can be made; however, it is the intent that the program continue to operate in basically the same form so that the Secretary is assured that its effectiveness is not impaired, and that additional costs are not shifted to medicare or medicaid.

This section is effective on enactment.

Reimbursement for Health Maintenance Organizations (HMO's) (Section 868)

Title VIII provides reimbursement for health maintenance organizations (HMO's) on the basis of a prospectively determined per capita amount equal to 95 percent of the cost of providing medicare benefits to beneficiaries outside the HMO. Any difference between the HMO's adjusted community rate (adjusted for the higher utilization of the elderly and disabled) and the medicare reimbursement is to be returned to medicare beneficiaries as benefits not otherwise covered under medicare.

Under present law, health maintenance organizations may contract for medicare reimbursement on either a cost or risk basis. However, only one HMO has opted to be reimbursed under the existing risk formula. HMO's have generally found the risk reimbursement formula unacceptable because retroactive adjustments are made which take into account the costs actually incurred by the HMO. The new risk

approximately $2 billion and will increase fiscal year 1981 revenues by approximately $4.2 billion. The Committee believes that this reduction of approximately $6.2 billion in the fiscal year 1981 budget deficit will contribute to a reduction in the inflationary pressures in the national economy.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by Titles VIII and IX, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

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TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

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DEFINITION OF WAGES

SEC. 209. For the purposes of this title, the term "wages" means remuneration paid prior to 1951 which was wages for the purposes of this title under the law applicable to the payment such remuneration, and remuneration paid after 1950 for employment, including the cash value of all remuneration paid in any medium other than cash; except that, in the case of remuneration paid after 1950, such term shall not include—

(a) * * *

* * * * * * *

[(f) The payment by an employer (without deduction from the remuneration of the employee) (1) of the tax imposed upon an employee under section 1400 of the Internal Revenue Code of 1939, or in the case of a payment after 1954 under section 3101 of the Internal Revenue Code of 1954, or (2) of any payment required from an employee under a State unemployment compensation law;]

(f) The payment by an employer (without deduction from the remuneration of the employee)—

(1) of the tax imposed upon an employee under section 3101 of the Internal Revenue Code of 1954, or

(2) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer;

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ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

SEC. 226.

(a) * * *

* * * * * * *

(c) For purposes of subsection (a)—

(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of title XVIII on his behalf for inpatient hospital services, post-hospital extended care services, [and post-hospital home health services] *and home health services* (as such terms are defined in part C of title XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1814 (f)) during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services [or post-hospital home health services] unless the discharge from the hospital required to qualify such services for payment under part A of title XVIII occurred (i) after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, or (ii) if he was entitled to hospital insurance benefits pursuant to subsection (b), at a time when he was so entitled; and

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TITLE V—MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

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APPROVAL OF STATE PLANS

SEC. 505. (a) In order to be entitled to payments from allotments under section 502, a State must have a State plan for maternal and child health services and services for crippled children which—

(1) * * *

* * * * * * *

(14) provides that acceptance of family planning services provided under the plan shall be voluntary on the part of the individual to whom such services are offered and shall not be a prerequisite to eligibility for or the receipt of any service under the plan; [and]

(15) provides—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of services under the plan and, where applicable, for providing guidance with respect thereto to the other State agency referred to in paragraph (2); and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform the function of determining whether institutions and agencies meet the re-

quirements for participation in the program under the plan under this title [.]; *and*

(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for entities also providing services under Title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1843(a).

PAYMENTS

SEC. 306. (a) * * *

* * * * * * *

(f) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth [and fifth], *fifth, and ninth* sentences of section 1842(b)(3); or

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TITLE X—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

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PART A—GENERAL PROVISIONS

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LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

SEC. 1122. (a) * * *

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(j) A capital expenditure made by or on behalf of a health care facility shall not be subject to review pursuant to this section if the obligation of the capital expenditure by the facility would not be required to be reviewed under section 1527 of the Public Health Service Act.

PROGRAM FOR DETERMINING QUALIFICATIONS FOR CERTAIN HEALTH CARE PERSONNEL

SEC. 1123. (a) The Secretary, in carrying out his functions relating to the qualifications for health care personnel under title XVIII, shall develop (in consultation with appropriate professional health organizations and State health and licensure agencies) and conduct (in conjunction with State health and licensure agencies) until December

31, [1977,] *1980*, a program designed to determine the proficiency of individuals (who do not otherwise meet the formal educational, professional membership, or other specific criteria established for determining the qualifications of practical nurses, therapists, laboratory technicians, and technologists, and cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists) to perform the duties and functions of practical nurses, therapists, laboratory technicians, technologists, and cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists. Such program shall include (but not be limited to) the employment of procedures for the formal testing of the proficiency of individuals. In the conduct of such program, no individual who otherwise meets the proficiency requirements for any health care specialty shall be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements.

* * * * * * *

DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

SEC. 1124. (a)(1) The Secretary shall by regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

(A) as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by Titles V, XVIII, XIX, and XX, or

(B) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under Titles V, XVIII, XIX, and XX,

supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity or in any subcontractor (as defined by the Secretary in regulations) in which the entity directly or indirectly has a 5 per centum or more ownership interest.

(2) As used in this section, the term "disclosing entity" means an entity which is—

(A) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, a renal disease facility, or a health maintenance organization [(as defined in section 1301(a) of the Public Health Service Act)];

(B) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established pursuant to Title V or under a State plan approved under Title XIX;

(C) a carrier or other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of Title XVIII, or both, or for purposes of a State plan approved under Title XIX) pursuant to (i) an agreement under section 1816,

(ii) a contract under section 1842, or (iii) an agreement with a single State agency administering or supervising the administration of a State plan approved under Title XIX; or

(D) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health related services with respect to which payment may be claimed by the entity under a State plan or program approved under Title XX.

(3) As used in this section, the term "person with an ownership or control interest" means, with respect to an entity, a person who—

(A)(i) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or

[(ii) is the owner (in whole or in part) of an interest of 5 per centum or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof; or]

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds $25,000 or 5 per centum of the total property and assets of the entity; or

(B) is an officer or director of the entity, if the entity is organized as a corporation; or

(C) is a partner in the entity, if the entity is organized as a partnership.

* * * * * * *

EXCLUSION OF CERTAIN INDIVIDUALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

SEC. 1127. (a) Whenever the Secretary determines that a physician or other individual has been convicted (on or after October 25, 1977, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such individual's participation in the delivery of medical care or services under Title XVIII or Title XIX, the Secretary—

(1) shall bar from participation in the program under Title XVIII, for such period as he may deem appropriate, each such individual otherwise eligible to participate in such program;

(2)(A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under Title XIX, of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) require each such agency to bar such individual from participation in such program for such period as he shall specify, which in the case of an individual specified in paragraph (1) shall be the period established pursuant to paragraph (1);

(B) may waive the requirement under subparagraph (A) to bar an individual from participation in a State plan program under Title XIX, where he receives and approves a request for

such a waiver with respect to that individual from the State agency administering or supervising the administration of such plan; and

(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such individual of the fact and circumstances of such determination, request that appropriate investigations be made and sanction invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.

(b) A determination made by the Secretary under this section shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services furnished under Title XVIII, such determination shall be effective in the manner provided in paragraphs (3) and (4) of section 1866(b) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(c) Any person who is the subject of an adverse determination made by the Secretary under subsection (a) shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

COORDINATED AUDITS

SEC. 1128. (a) If an entity provides services reimbursable on a cost-related basis under Title V or XIX, as well as services reimbursable on such a basis under Title XVIII, the Secretary shall require, as a condition for payment to any State under Title V or XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of Title XVIII. The Secretary shall specify by regulation such methods as he finds feasible and equitable for the apportionment of the cost of coordinated audits between the program established under Title V or XIX and the program established under Title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to Title V or XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be in excess of the amount that would have been apportioned to the State under the title (for the expenses of the State incurred in the common audit) if it had participated in the common audit.

(b)(1) In the case of entities which have audits coordinated under subsection (a), the Secretary shall establish one or more projects to

demonstrate the feasibility of creating a single coordinated appeal hearing to adjudicate those administrative cost items which are determined under such a coordinated audit and which such entities dispute and appeal.

(2) In the case of a demonstration project under this subsection, the Secretary may waive such requirements of Title V, XVIII, or XIX as would prevent carrying out the project or would require duplicative activity or otherwise create unnecessary administrative burdens in carrying out the project.

(3) The Secretary shall report to Congress not later than April 1, 1982, on demonstration projects conducted under this subsection, including the reaction of the entities involved and estimates of any savings effected through reduction of duplication of appeal hearings, and shall include in such report recommendations for such legislation as the Secretary deems appropriate to insure the maximum feasible coordination of such appeal hearings.

(4) The Secretary shall also provide for the review of the feasibility of establishing a single coordinated process for the collection of overpayments established in a coordinated audit under subsection (a). The Secretary shall report to Congress not later than April 1, 1981, on such review and on such recommendations for changes in legislation as the Secretary deems appropriate.

DEMONSTRATION PROJECTS FOR REQUIRING SECOND OPINIONS FOR CERTAIN ELECTIVE SURGICAL PROCEDURES UNDER MEDICARE AND MEDICAID

SEC. 1129. (a)(1) The Secretary is authorized to make grants to, and enter into contracts with, public and private nonprofit entities, including professional standards review organizations designated (conditionally or otherwise) under part B of this title and medical societies, for the conduct of demonstration projects for the purpose of determining the cost-effectiveness and appropriateness of requiring that a second opinion with respect to specified elective surgical procedures (defined in subsection (f)(1)) be provided before payment may be made under Title XVIII or under a State plan approved under Title XIX with respect to the performance of the procedure.

(2) To the extent feasible, the Secretary shall provide under this section for—

(A) demonstration projects applicable to all specified elective surgical procedures proposed to be furnished to individuals entitled to hospital insurance benefits under part A, and enrolled under the supplementary medical insurance program under part B, of Title XVIII of this Act, and

(B) demonstration projects applicable to all specified elective surgical procedures proposed to be furnished to individuals eligible for medical assistance under State plans approved under Title XIX of this Act.

(3) The Secretary shall provide, to the extent feasible—

(A) for at least seven demonstration projects under this section,

(B) that the number of such projects conducted be equally divided between projects described in paragraph (2)(A) and projects described in paragraph (2)(B), and

(C) for the conduct of such projects in a variety of geographic settings and covering a variety of sizes of populations, in order to determine the relative effectiveness of requiring second opinions in different areas of the country and under programs of different sizes.

(b)(1) No grant may be made or contract entered into under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary may provide.

(2) The amount of any grant or contract under this section shall be determined by the Secretary.

(3) Grants and payments under contracts made for demonstration projects and related administrative expenses (including expenses for analysis of data) described—

(A) insubsection (a)(2)(A) shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841), and

(B) in subsection (a)(2)(B) shall be made from funds appropriated under Title XIX of this Act.

Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section.

(4) In addition to any other authority provided under part B of this title, professional standards review organizations designated (conditionally or otherwise) under such part are authorized to receive grants and enter into contracts for demonstration projects under this section.

(5) For administrative expenses (including analysis of data) associated with demonstration projects under this section, there is authorized to be appropriated for fiscal year 1981 an amount, not to exceed $7,000,000, to remain available until expended.

(c) No grant or contract shall be made with respect to a demonstration project under this section unless the project meets the following requirements:

(1) The project must potentially apply to a sufficiently large population of individuals eligible for benefits under part A of title XVIII (in the case of a project described in subsection (a)(2)(A)) or under the State plan (in the case of a project described in subsection (a)(2)(B)) for specified elective surgical procedures recommended during a two-year period, so as to provide for statistically valid data to properly evaluate the project.

(2)(A) The project must provide (through the entity or the Secretary) for notice to the applicable population, and, to the extent feasible, to physicians and hospitals which may provide specified elective surgical procedures for such population, of the existence of the demonstration project and the requirement of subsection (d) for a second opinion as a condition of payment for such procedure and must include in such notice made to the applicable population a general description of the procedure and techniques available for the treatment of the condition for treat-

ment of which a specified elective surgical procedure has been recommended.

(B) The project must provide for making available to individuals covered under the project lists of qualified physicians who have indicated that they will provide, in accordance with the provisions of the project, written opinions with respect to the necessity and appropriateness of particular specified elective surgical procedures.

(3) To the extent practicable and consistent with the protection of patient privacy, the project must be so designed as—

(A) to prevent the qualified physician providing the second or third opinion from knowing the identity of the physician who provided a previous opinion with respect to that procedure, and

(B) to avoid duplication of laboratory and other tests required in order to render such an opinion.

(4) The project must provide that for the transmittal to the Secretary—

(A) of interim data on the project's performance not later than eighteen months after the date the project is initiated, and

(B) of final data on its performance not later than six months after the end of the two-year period described in paragraph (1).

(d)(1) Notwithstanding any other provision of law (except as provided in paragraph (2)), if a specified elective surgical procedure to be furnished to an individual is covered under a demonstration project under this section applicable to Title XVIII or to a State plan approved under Title XIX, no payment may be made under such title or plan, respectively, with respect to the procedure unless the individual has been furnished, before the procedure is undertaken, at least—

(A) one written opinion by a physician described in subsection (f)(2)(A), and

(B) one written opinion by a qualified physician (as defined in subsection (f)(2)),

based on all factors deemed relevant to the determination, respecting the necessity and appropriateness of the procedure.

(2) Paragraph (1) shall not apply—

(A)(i) in the case of a demonstration project described in subsection (a)(2)(A), to procedures furnished by or through a health maintenance organization under a risk sharing contract entered into with the Secretary pursuant to section 1876(i)(2)(A), or

(ii) in the case of a demonstration project described in subsection (a)(2)(B), to procedures furnished by or through a health maintenance organization which provides to the enrollees, on a prepaid capitation risk basis or on any other risk basis, such procedures; and

(B) in the case in which the patient is unable, because of severe physical or cognitive limitations, to understand the requirement of such paragraph or in such other cases as the Secretary determines that equity requires that such paragraph not apply.

(e) The Secretary shall analyze the data on demonstration projects transmitted to him under this section and shall submit to the Congress—

(1) not later than two years after the date of the enactment of this Act, an interim report on the demonstration projects assisted under this section, and

(2) not later than four years after the date of the enactment of this Act, a final report on the demonstration projects assisted under this section.

Such final report shall include such recommendations for changes in legislation with respect to imposing the requirement described in subsection (d) with respect to some or all of the specified elective surgical procedures as the Secretary determines to be appropriate.

(f) for purposes of this section:

(1) The term "specified elective surgical procedure" means—

(A) in the case of a demonstration project applicable to the medicare program—

(i) cholycystectomy,
(ii) menisectomy,
(iii) prostatectomy,
(iv) cataract surgery,
(v) hemorrhoidectomy, and
(vi) excision of varicose veins; and

(B) in the case of a demonstration project applicable to State plans approved under Title XIX of this Act—

(i) hysterectomy,
(ii) menisectomy,
(iii) submucous resection,
(iv) hemorrhoidectomy,
(v) excision of varicose veins, and
(vi) tonsillectomy and adenoidectomy,

if such procedures are medically necessary to treat other than an emergency medical condition. In addition, such term includes such other elective surgical procedures as the Secretary, in his discretion, determines to be appropriate.

(2) The term "qualified physician" means, with respect to an opinion on a specified elective surgical procedure for treatment of a medical condition of a particular patient, a physician who—

(A) is a board-eligible or certified specialist with respect to the procedure or with respect to treatment of the medical condition or who possesses such other qualifications with respect to such procedure or treatment as the Secretary may specify;

(B) agrees not to perform the surgical procedure for which the opinion is sought (except under emergency conditions); and

(C) is not affiliated with a physician who provided a previous opinion with respect to such treatment of such patient.

ENCOURAGEMENT OF NONPROFIT HOSPITAL PHILANTHROPY

SEC. 1134. (a) It is the policy of the United States that philanthropic support for health care be encouraged and expanded, espe-

cially in support of experimental and innovative efforts to improve the health care delivery system.

(b) For purposes of determining under Titles V, XVIII, and XIX the reasonable costs of services furnished by nonprofit hospitals, unrestricted grants, gifts, and income from endowments shall not be deducted from any operating costs of such hospitals, and, in addition, the following items shall not be deducted from any operating costs of such hospitals:

(1) A donor designated or restricted grant, gift, or income from an endowment, as defined in section 405.423(b)(2) of title 42 of the Code of Federal Regulations.

(2) An unrestricted grant or gift, or income from such a grant or gift, which is not available for use as operating funds because of its designation by the hospital's governing board.

(3) A grant or similar payment which is made by a governmental entity and which is not available, under the terms of the grant or payment, for use as operating funds.

(4) The sale or mortgage of any real estate or other capital assets of the hospital which the hospital acquired through a gift or grant and which is not available for use as operating funds under the terms of the gift or grant or because of its designation by the hospital's governing board, except for recovery of the appropriate share of gains and losses realized from the disposal of depreciable assets.

(5) A sinking fund which is (A) created by the hospital in order to meet a condition imposed by a third party for the third party's financing of a capital improvement of the hospital, and which fund is used exclusively to make payments to such third party for the financing of the capital improvement.

PART B—PROFESSIONAL STANDARDS REVIEW

* * * * * * *

DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1152. (a) * * *

(b) For purposes of subsection (a), the term "qualified organizations" means—

(1) when used in connection with any area—

(A) an organization (i) which is a nonprofit professional association (or a component organization thereof), (ii) which is composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area, *and, if the organization so elects, of other health care practitioners engaged in the practice of their professions in such area who hold independent hospital admitting privileges,* (iii) the membership of which includes a substantial proportion of all such physicians in such area, (iv) which is organized in a manner which makes available professional competence to review health care services of the types and kinds with respect to which Professional Standards Review Organizations have review responsibilities under this part,

(v) the membership of which is voluntary and open to all doctors of medicine or osteopathy licensed to engage in the practice of medicine or surgery in such area without requirement of membership in or payment of dues to any organized medical society or association, and (vi) which does not *(except as otherwise provided under section 1155(c))* restrict the eligibility of any member for service as an officer of the professional Standards Review Organization or eligibility for and assignment to duties of such Professional Standards Review Organization, or, subject to subsection (c)(1),

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TRIAL PERIOD FOR PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1154. (a) * * *

(b) During any such trial period (which may not exceed 48 months except as provided in subsection (c), the Secretary may require a Professional Standards Review Organization to perform, in addition to review of health care services [provided by or in institutions, only such of the duties and functions required under this part of Professional Standards Review Organization as he determines such organization to be capable of performing] *(other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals, only such of the duties and functions as he requires the organization to perform under subsection (f)(2) or subsection (f)(4) and which the organization is capable of performing.* The number and type of such duties shall, during the trial period, be progressively increased as the organization becomes capable of added responsibility so that, by the end of such period, such organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner, the activities and functions required of [Professional Standards Review Organizations under this part with respect to the review of health care services provided by or in institutions (including ancillary services) and, in addition, review of such other health care services as the Secretary may require] *that Professional Standards Review Organization under this part.* Any of such duties and functions not performed by such organization during such period shall be performed in the manner and to the extent otherwise provided for under law.

(c) If the Secretary finds that an organization designated under subsection (a) has been unable to perform satisfactorily all of the duties and functions required under this part *of that organization* for reasons beyond the organization's control, he may extend such organization's trial period for an additional period not exceeding twenty-four months.

* * * * * * *

(f)(1) The Secretary shall establish a program (hereinafter in this subsection referred to as the "program") for the evaluation of the cost-effectiveness of review of particular health care services by Professional Standards Review Organizations.

(2) In order to demonstrate the cost-effectiveness of requiring review of particular health care services before such review is generally

required, the program shall be designed in a manner so that the Secretary will require particular Professional Standards Review Organizations, chosen by a statistically valid method that will permit a valid evaluation of the cost-effectiveness of such review, to review particular health care services.

(3) The program shall provide for the evaluation of cost-effectiveness of the review of particular health care services under the program, particularly in comparison with areas in which such review was not required or performed.

(4) Based upon such evaluation, or upon an evaluation of comparable statistical validity, and a finding that review of particular health care services is cost-effective or yields other significant benefits, the Secretary shall specify such particular health care services which Professional Standards Review Organizations (either generally or under such conditions and circumstances as the Secretary may specify) have the duty and function of reviewing under this part.

(5) For purposes of this subsection, the term "particular health care services" does not include health care services (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals.

DUTIES AND FUNCTIONS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1155. (a)(1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall be the duty and function of each Professional Standard Review Organization for any area to assume, [at the earliest date practicable] *to the extent and at the time specified by the Secretary under section 1154(f);* responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services (except as provided in paragraph (7)) and items for which payment may be made (in whole or in part) under this Act for the purpose of determining whether—

(A) such services and items are or were medically necessary;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type.

[(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

[(A) any elective admission to a hospital, or other health care facility, or

[(B) any other health care service which will consist of extended or costly courses of treatment.

whether such service, if provided, or if provided by a particular health

care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in clauses (A) and (C) of paragraph (1).]

(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

(A) any elective admission to a hospital or other health care facility (including admissions occurring on weekends), and

(B) any routine diagnotic services furnished in connection with such an admission,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in subparagraphs (A) and (C) of paragraph (1). Each such Organization may be directed by the Secretary to exercise such authority where the Secretary finds (consistent with section 1154(f) that such determinations can be made on a timely basis by the Organization and appropriate procedures will be applied to assure prompt notification of such determinations to providers, physicians, practitioners, and persons on whose behalf payment may be made under this Act for services and items.

* * * * * * *

(7)(A) Except as provided in subparagraph (B), a Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities (as defined in section 1905(c)) and in public institutions for the mentally retarded (described in section 1905(a)(1) only, *consistent with section 1154(f)*, if (i) the Secretary finds, on the basis of such documentation as he may require from the State, that the single State agency which administers or supervises the administration of the State plan approved under Title XIX for that State is not performing effective review of the quality and necessity of health care services provided in such facilities and institutions, or (ii) the State requests such organization to assume such responsibility.

(B) A Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities in the State that are also skilled nursing facilities (as defined in section 1861(j)), to the extent (*consistent with section 1154 (f)*) that the Secretary finds that the performance of such function by the single State agency (described in subparagraph (A)) for that State is inefficient.

(8) Each Professional Standards Review Organization shall consult (with such frequency and in such manner as may be prescribed by the Secretary) with representatives of health care practitioners (other than physicians described in section 1861(r)(1)) and of institutional and noninstitutional providers of health care services, in relation to the Professional Standards Review Organization's responsibility for the review under paragraph (1) of the professional activities of such practitioners and providers.

* * * * * * *

(e)(1) Each Professional Standards Review Organization shall utilize the services of, and accept the findings of, the review committees of a hospital (including any skilled nursing facility, as defined in section 1861(j), or intermediate care facility, as defined in section 1905(c), which is also a part of such hospital) or other operating health care facility or organization (other than such a skilled nursing facility or intermediate care facility which is not a part of a hospital) located in the area served by such organization, but only when and only to the extent and only for such time that such committees in such hospital or other operating health care facility or organization have demonstrated to the satisfaction of such organization their capacity [effectively and in timely fashion] *effectively, efficiently, and in timely fashion* to review activities in such hospital or other operating health care facility or organization (including the medical necessity of admissions, types and extent of sevices ordered, and lengths of stay) so as to aid in accomplishing the purposes and responsibilities described in subsection (a)(1), except where the Secretary disapproves, for good cause, such acceptance.

(2) The Secretary may prescribe regulations to carry out the provisions of this subsection.

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[(g)(1) Where a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) requests review responsibility with respect to services furnished in shared health facilities, the Secretary must give priority to such request, with the highest priority being assigned to requests from organizations located in areas with substantial numbers of shared health facilities.

[(2) The Secretary shall require any Professional Standards Review Organization which is capable of exercising review responsibility with respect to ambulatory care services to perform review responsibility with respect to such services on and after a date not earlier than the date the organization is designated as a Professional Standards Review Organization (other than under section 1154) and not later than two years after the date the organization has been so designated, but any such designated Professional Standards Review Organization may be approved to perform such review responsibility at any earlier time if such organization applies for, and is found capable of exercising, such responsibility.]

(h) If the Secretary has designated an organization (other than under section 1154) as a Professional Standards Review Organization, but that organization has not assumed responsibility for the review of particular activities in its area included in subsection (a)(1), the Secretary may designate another qualified Professional Standards Review Organization (in reasonable proximity to the providers and practitioners whose services are to be reviewed) to assume the responsibility for the review of some or all of those particular activities.

STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCILS; ADVISORY GROUPS TO SUCH COUNCILS

SEC. 162. (a) * * *

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(c)(1) The Statewide Professional Standards Review Council for any State [(or in a State which does not have such Council, the Professional Standards Review Organizations in such State which have agreements with the Secretary)] shall be advised and assisted in carrying out its functions by an advisory group (of not less than seven nor more than eleven members) which shall be made up of representatives (*including at least one registered professional nurse and at least one doctor of dental surgery or of dental medicine*) of health care practitioners (other than physicians) and hospitals and other health care facilities which provide within the State health care services for which payment (in whole or in part) may be made under any program established by or pursuant to this Act.

(2) The Secretary shall by regulations provide the manner in which members of such advisory group shall be selected by the Statewide Professional Standards Review Council [(or Professional Standards Review Organizations in States without such Councils)].

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NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

SEC. 1163. (a)(1) There shall be established a National Professional Standards Review Council (hereinafter in this section referred to as the "Council") which shall consist of eleven physicians, *one doctor of dental surgery or of dental medicine, one registered professional nurse, and one other health practitioner (other than a physician as defined in section 1861(r)(1))*, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

(2) Members of the Council shall be appointed for a term of three years, except that the Secretary may provide, in the case of any terms scheduled to expire after January 1, 1978, for such shorter terms as will ensure that (on a continuing basis) the terms of no more than [four] *five* members expire in any year. Members of the Council shall be eligible for reappointment.

(3) The Secretary shall from time to time designate one of the *physician* members of the Council to serve as Chairman thereof.

(b) [Members] *Physician members* of the Council shall consist of physicians of recognized standing and distinction in the appraisal of medical practice. A majority of such members shall be physicians who have been recommended by the Secretary to serve on the Council by national organizations recognized by the Secretary as representing practicing physicians. The membership of the Council shall include physicians who have been recommended for membership on the Council by consumer groups and other health care interests.

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MEDICAL OFFICES IN AMERICAN SAMOA, THE NORTHERN MARIANA ISLANDS, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS TO BE INCLUDED IN THE PROFESSIONAL STANDARDS REVIEW PROGRAM

SEC. 1173. For purposes of applying this part [(except sections 1155(c) and 1163)] (*except section 1155(c)*) to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific

Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.

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TITLE XVIII--HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

DESCRIPTION OF PROGRAM

SEC. 1811. The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital [and related post-hospital services], *related post-hospital, and home health services* in accordance with this part for (1) individuals who are age 65 or over and are entitled to retirement benefits under Title II of this Act or under the railroad retirement system; (2) individuals under age 65 who have been entitled for not less than 24 consecutive months to benefits under Title II of this Act or under the railroad retirement system on the basis of a disability; and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

SCOPE OF BENEFITS

SEC. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus one day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services for up to 100 days during any spell of illness; and

[(3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next.]

(3) home health services.

* * * * * * *

[(d) Payment under this part may be made for post-hospital home health services furnished an individual only during the one-year period described in section 1861(n) following his most recent hospital discharge which meets the requirements of such section, and only for the first 100 visits in such period. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items or services described in section 1861(m), shall be determined in accordance with regulations.]

(e) For purposes of subsections [(b), (c), and (d)] (*b*) *and* (*c*) inpatient hospital services, inpatient psychiatric hospital services, [post-hospital extended care services, and post-hospital home health services] *and post-hospital extended care services* shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

(f) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.

DEDUCTIBLES AND COINSURANCE

SEC. 1813. (a)(1) The amount payable for inpatient hospital services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to—

(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812(a)(1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).

[(2) The amount payable to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by a deduction equal to the cost of the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during such spell of illness.]

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CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in t e last 3 calendar months of any calendar year to have been furnished in the suceeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

(2) physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necesary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(B) in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment can or could reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition noncommunicable;

(C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

(D) in the case of [post-hospital] home health services, such services are or were required because the individual is or

was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical, *occupational*, or speech therapy [, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) or post-hospital extended care services]; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; or

(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status *or because of the severity of the dental procedure*, requires hospitalization in connection with the provision of such [dental] services;

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

(5) in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to (A) improve his condition or (B) render it noncommunicable;

(6) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital or skilled nursing facility, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility), and

(7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861 (k) (4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization to review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), or (E) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. *With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than January 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan.*

Amount Paid to Providers

[(b) (1) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be—

[(1) the lesser of (A) the reasonable cost of such services, as determined under section 1861(v) *and as further limited by section 1881(b)(2)(B)*, or (B) the customary charges with respect to services; or

[(2) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services.]

(b)(1) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be the lesser of the reasonable cost of such services, as determined under section 1861(v) and as further limited by section 1881(b)(2)(B), or the amount determined under paragraph (2).

(2) If some or all of the hospitals in a State have been reimbursed for services (for which payment may be made under this part) pur-

suant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967 or section 222(a) of the Social Security Amendments of 1972, if the rate of increase in such hospitals in their costs per hospital inpatient admission of individuals entitled to benefits under this part over the duration of such project was equal to or less than such rate of increase for admissions of such individuals with respect to all hospitals in the United States during such period, and if either the State has legislative authority to operate such system and the State elects to have reimbursement to such hospitals made in accordance with this paragraph or the system is operated through a voluntary agreement of hospitals and such hospitals elect to have reimbursement to those hospitals made in accordance with this paragraph, then such hospitals shall continue to be reimbursed under such system until the Secretary determines that—

(A) a third-party payor reimburses such a hospital on a basis other than under such system, or

(B) the rate of increase for the previous three-year period in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part is greater than such rate of increase for admissions of such individuals with respect to all hospitals in the United States for such period.

No Payments to Federal Providers of Services

(c) Subject to section 1880, no payment may be made under this part (except under subsection (d) or subsection [j] (*h*)) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

* * * * * * *

[Payment for Posthospital Extended Care Services

[(h)(1) An individual shall be presumed to require the care specified in subsection (a)(2)(C) of this section for purposes of making payment to an extended care facility (subject to the provisions of section 1812) for posthospital extended care services which are furnished by such facility to such individual if—

[(A) the certification referred to in subsection (a)(2)(C) of this section is submitted prior to or at the time of admission of such individual to such extended care facility,

[(B) such certification states that the medical condition of the individual is a condition designated in regulations,

[(C) such certification is accompanied by a plan of treatment for providing such services, and

[(D) there is compliance with such other requirements and procedures as may be specified in regulations,

but only for services furnished during such limited periods of time with respect to such conditions of the individual as may be prescribed

in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum length of stay in an institution generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

[(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply, after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A), (B), or (C) of paragraph (1).

[Payment for Posthospital Home Health Services

[(i)(1) An individual shall be presumed to require the services specified in subsection (a)(2)(D) of this section for purposes of making payment to a home health agency (subject to the provisions of section 1812) for posthospital home health services furnished by such agency to such individual if—

[(A) the certification and plan referred to in subsection (a)(2)(D) of this section are submitted in timely fashion prior to the first visit by such agency,

[(B) such certification states that the medical condition of the individual is a condition designated in regulations, and

[(C) there is compliance with such other requirements and procedures may be specified in regulations,

but only for services furnished during such limited numbers of visits with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum period of home confinement generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

[(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A) or (B) of paragraph (1).]

Payment for Certain Hospital Services Provided in Veterans' Administration Hospitals

[(j)](*h*)(1) Payments shall also be made to any hospital operated by the Veterans' Administration for inpatient hospital services furnished in a calendar year by the hospital, or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital benefits under section 226 even though the hospital is a Federal

provider of services if (A) the individual was not entitled to have the services furnished to him free of charge by the hospital, (B) the individual was admitted to the hospital in the reasonable belief on the part of the admitting authorities that the individual was a person who was entitled to have the services furnished to him free of charge, (C) the authorities of the hospital, in admitting the individual, and the individual, acted in good faith, and (D) the services were furnished during a period ending with the close of the day on which the authorities operating the hospital first became aware of the fact that the individual was not entitled to have the services furnished to him by the hospital free of charge, or (if later) ending with the first day on which it was medically feasible to remove the individual from the hospital by discharging him therefrom or transferring him to a hospital which has in effect an agreement under this title.

(2) Payment for services described in paragraph (1) shall be in an amount equal to the charge imposed by the Veterans' Administration for such services, or (if less) the reasonable costs for such services (as estimated by the Secretary). Any such payment shall be made to the entity to which payment for the services involved would have been payable, if payment for such services had been made by the individual receiving the services involved (or by another private person acting on behalf of such individual).

* * * * * * *

USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

SEC. 1816. (a) * * *

* * * * * * *

(c)(1) Notwithstanding subsections (a) and (d), the Secretary, after taking into consideration any preferences of providers of services, may assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section, if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such assignment or reassignment would result in the more effective and efficient administration of this part.

(2) Notwithstanding subsections (a) and (d), the Secretary may (*subject to the provisions of paragraph* (4)) designate a national or regional agency or organization which has entered into an agreement with him under this section to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such designation would result in more effective and efficient administration of this part.

(3)(A) Before the Secretary makes an assignment or reassignment under paragraph (1) of a provider of services to the other than the agency or organization nominated by the provider, he shall furnish (i) the provider and such agency or organization with a full explanation of the reasons for his determination as to the efficiency and effectiveness of the agency or organization to perform the functions

required under this part with respect to the provider, and (ii) such agency or organization with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(B) Before the Secretary makes a designation under paragraph (2) with respect to a class of providers of services, he shall furnish (i) such providers and the agencies and organizations adversely affected by such designation with a full explanation of the reasons for his determination as to the efficiency and effectiveness of such agencies and organizations to perform the functions required under this part with respect to such providers, and (ii) the agencies and organizations adversely affected by such designation with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(4) Notwithstanding subsections (a) and (d) and paragraphs (1), (2), and (3), of this subsection, the Secretary shall designate regional agencies or organizations which have entered into an agreement with him under this section to perform functions under such agreement with respect to home health agencies (as defined in section 1861(o)) in the region, except that in assigning such agencies to such designated regional agencies or organizations the Secretary shall assign a home health agency which is a subdivision of a hospital (and such agency and hospital are affiliated or under common control) only if, after applying such criteria relating to administrative efficiency and effectiveness as he shall promulgate, he determines that such assignment would result in the more effective and efficient administration of this title.

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of —

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services [for up to 100 visits during a calendar year];

(B) medical and other health services furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, [or]

(II) a physician to a patient in a hospital which has a teaching program approved as specified in

paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital) [, unless either clause (A) or (B) of paragraph (7) of such section is met, and] *where the conditions specified in paragraph (7) of section are met, or*

(III) a physician to a patient in a community mental health center or to a patient in a comprehensive outpatient rehabilitation facility; and

(ii) services for which payment may be made pursuant to section 1835(b)(2); and

(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies; [and]

(D) rural health clinic services[.]*;*

(E) community mental health center services;

(F) comprehensive outpatient rehabilitation facility services; and

(G) facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1) and performed in an ambulatory surgical center (which meets health, safety, and other standards specified by the Secretary in regulations).

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology *who has in effect an agreement with the Secretary by which the physicians' agrees to accept an assignment (as provided for in section 1842(b)(3)(B)(ii)) for all physicians' services furnished by*

him for hospital inpatients enrolled under this part, the amounts paid shall be equal to 100 percent of the reasonable charges for such services, (C) with respect to expenses incurred, for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (g) of this section), [and] (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, *(F) with respect to expenses incurred for preadmission diagnostic radiological or pathological services for which payment may be made under this part and which are furnished to an individual by the outpatient department of a hospital within seven days of such individual's admission to the same hospital as an inpatient or, to the extent practicable as determined by regulations prescribed by the Secretary, to another hospital by a physician in the field of radiology or pathology who has an agreement in effect with the Secretary by which the physicians agrees to accept an assignment (as provided for in section 1842(b)(3)(B)(ii)) for all physicians' services furnished by him for such services to individuals enrolled under this part, the amounts paid shall be equal to the reasonable charges for such services, (G) with respect to items and services described in section 1861(s)(10), the amounts paid shall be 100 percent of the reasonable charges for such items and services, and (A) with respect to a second or third opinion as to necessity and appropriateness of specified elective surgical procedures in the case of a demonstration project described in section 1129(f)(1)(A), the amounts paid shall be equal to 100 percent of the reasonable charge for such opinion.*

[(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraph (D) of section 1832(a)(2))"—with respect to home health services, 100 percent, and with respect to other services (unless otherwise specified in section 1881), 80 percent of—

[(A) the lesser of (1) the reasonable cost of such services, as determined under section 1861(v), or (ii) the customary charges with respect to such services; or

[(B) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2); or

[(C) if such services are services to which the next to last sentence of section 1861(p) applies, the reasonable charges for such services, and

[(3) in the case of services described in section 1832(a)(2)(D), 80 percent of costs which are reasonable and related to the

cost of furnishing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations including those authorized under section 1861(v)(1)(A).]

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D), (E), (F), and (G) of such section and in paragraph (5) of this subsection)—

(A) with respect to home health services and to items and services described in section 1861(s)(10), the reasonable cost of such services, as determined under section 1861(v);

(B) with respect to other services (except those described in subparagraphs (C) of this paragraph), the reasonable costs of such services, as so determined, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such costs;

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

(3) in the case of services described in subparagraphs (D), (E), and (F) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)) exceed 80 percent of such costs; and

(4) in the case of facility services described in subparagraph (G) of section 1832(a)(2), the applicable amount described in subparagraph (A) of section 1833(i)(2); and

(5) in the case of preadmission diagnostic services described in section 1861(s)(2)(C) which are furnished to an individual by the outpatient department of a hospital within 7 days of such individual's admission to the same hospital as an inpatient or (to the extent practicable as determined by regulations prescribed by the Secretary) to another hospital, the reasonable costs for such services.

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $60; except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year and applied toward such individual's deductible under this section for such preceding year, [and] (2) such total amount shall not include expenses incurred (A) for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of

radiology or pathology *who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(B)(ii)) for all physicians' services furnished by him for hospital inpatients enrolled under this part, or (B) for items and services described in section 1861(s)(10), (3) such deductible shall not apply with respect to home health services, and (4) such total amount shall not include expenses incurred for a second or third opinion described in subsection (a)(1)(G) for an elective surgical procedure.* [The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.]

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital *and not a patient of a community mental health center* at the time such expenses are incurred. [there] *not more than $937.50* shall be considered as incurred expenses for purposes of subsections (a) and (b) [only whichever of the following amounts is the smaller:

[(1) $312.50, or

[(2) 62½ percent of such expenses.].

* * * * * * *

(g) In the case of services described in the next to last sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than [$100] *$500* shall be considered as incurred expenses for purposes of subsections (a) and (b).

[(g)] *(h)* With respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the Secretary is authorized to establish a payment rate which is acceptable to the laboratory and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such a rate.

(i)(1) The Secretary shall, in consultation with the National Professional Standards Review Council and appropriate medical organizations, specify surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient

facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center or hospital outpatient department.

(2)(A) The amount of payment to be made for facility services furnished in connection with surgical procedures specified pursuant to paragraph (1) and furnished to an individual in an ambulatory surgical center shall be equal to an amount established by the Secretary with respect to each such procedure which (i) takes into account the costs incurred by such centers, or classes of centers, generally in providing the services appropriate for the performance of such services, and (ii) takes such costs into account in such a manner which will assure that the performance of the service in such an ambulatory surgical center will result in substantially less amounts paid under this title than would have been paid if the services had been furnished on an inpatient basis. The amount so established shall be reviewed periodically and may be adjusted, when appropriate, to take account of varying conditions in different areas.

(B) The amount of payment to be made under this part for services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with surgical procedures (specified pursuant to paragraph (1) of this subsection) in an ambulatory surgical center or a hospital outpatient department shall be the reasonable charge for such services if the physician accepts an assignment, as provided for in section 1842 (b)(3)(B)(ii), with respect to such payment.

[LIMITATION ON HOME HEALTH SERVICES

[SEC. 1834. (a) Payment under this part may be made for home health services furnished an individual during any calendar year only for 100 visits during each year. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items and services described in section 1861(m), shall be determined in accordance with regulations.

[(b) For purposes of subsection (a), home health services shall be taken into account only if payment under this part is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services.]

LIMITATION ON COMMUNITY MENTAL HEALTH CENTER SERVICES

SEC. 1834. Payment under this part may be made for community mental health center services furnished an individual for—

(1) up to 15 outpatient visits during any calendar year; and

(2) up to 60 partial hospitalization visits to such a center during any calendar year.

Services shall be taken into account for purposes of paragraphs (1) and (2) only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services under this part.

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832 (a) (2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical, *occupational*, or speech therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(B) (*i*) in the case of medical and other health services except services described in subparagraphs (B), (C), and (D) of section 1861(s) (2), such services are or were medically required; [and]

(*ii*) *in the case of services furnished by a physician described in section 1861(r)(6) to an individual described in such section, such services are or were required for the treatment of mental psychoneurotic, or personality disorders:*

(C) in the case of outpatient physical therapy services, (i) such services are or were required because the individual needed physical therapay services, (ii) a plan for furnishing such services has been established, and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established *by a physician or by the speech pathologist providing such services* and is periodically

reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician[.];

(E) in the case of community mental health center services, (i) such services are or were required in connection with the treatment of mental, psychoneurotic, or personality disorders, (ii) a plan for furnishing such services has been established by a physician (as defined in section 1861(r)(1)) or other mental health professional (as defined for this purpose in regulations by the Secretary) and is periodically reviewed and approved by a physician, (iii) such services are or were furnished while the individual is or was under the case management of a physician (as defined in section 1861 (r)(1)), and (iv) in the case of services provided with respect to a partial hospitalization visit, the individual would otherwise require or have required (in the professional judgment of such physician) inputient psychiatric services;

(F) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; and

(G) in the case of services furnished in connection with surgical procedures, specified pursuant to section 1833(i)(1), in an ambulatory surgical center, such services are or were medically required.

To the extent provided by regulations, the certification and recertification requirements of paragraphs (2) shall be deemed satisfied where at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B), but only with respect to the furnishing of outpatient physical therapy services (as therein defined). *With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than January 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan.*

* * * * * * *

ENROLLMENT PERIODS

SEC. 1837. (a) An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

[(b) No individual may enroll under this part more than twice.]

* * * * * * *

[(c) There shall be a general enrollment period, after the period described in subsection (c), during the period beginning on January 1 and ending on March 31 of each year beginning with 1969.]

(c) There shall be a general enrollment period which is any period after the period described in subsection (d).

(g) All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 226(a)(2)(B), his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th consecutive month of such entitlement, and shall reoccur with each continuous period of eligibility (as defined in section 1839(e)) and upon attainment of age 65;

(2)(A) in the case of an individual who is entitled to monthly benefits under section 202 or 223 on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 202 during the first 3 months of such period, his enrollment shall be deemed to have occurred in the third month of his initial enrollment period, and

(B) in the case of an individual who is not entitled to benefits under section 202 on the first day of his initial enrollment period and does not become so entitled during the first 3 months of such period, his enrollment shall be deemed to have occurred in the month in which he files the application establishing his entitlement to hospital insurance benefits provided such filing occurs during the last 4 months of his initial enrollment period; and

(3) in the case of an individual who would otherwise satisfy subsection (f) but does not establish his entitlement to hospital insurance benefits until after the last day of his initial enrollment period (as defined in subsection (d) of this section), his enrollment shall be deemed to have occurred on the first day of [the earlier of then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section)] *the month in which the individual files an application establishing such entitlement.*

* * * * * * *

COVERAGE PERIOD

SEC. 1838. (a) The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his "coverage period") shall begin on whichever of the following is the latest:

(1) July 1, 1966 or (in the case of a disabled individual who has not attained age 65) July 1, 1973, or

(2)(A) in the case of an individual who enrolls pursuant to subsection (d) of section 1837 before the month in which he first satisfies paragraph (1) or (2) of section 1836, the first day of such month, or

(B) in the case of an individual who enrolls pursuant to such subsection (d) in the month in which he first satisfies such paragraph, the first day of the month following the month in which he so enrolls, or

(C) in the case of an individual who enrolls pursuant to such subsection (d) in the month following the month in which he first satisfies such paragraph, the first day of the second month following the month in which he so enrolls, or

(D) in the case of an individual who enrolls pursuant to such subsection (d) more than one month following the month in which he satisfies such paragraph, the first day of the third month following the month in which he so enrolls, or

(E) in the case of an individual who enrolls pursuant to subsection (e) of section 1837, [the July 1] *the first day of the third month* following the month in which he so enrolls; or

(3)(A) in the case of an individual who is deemed to have enrolled on or before the last day of the third month of his initial enrollment period, the first day of the month in which he first meets the applicable requirements of section 1836 or July 1, 1973, whichever is later, or

(B) in the case of an individual who is deemed to have enrolled on or after the first day of the fourth month of his initial enrollment period, as prescribed under subparagraphs (B), (C), (D), and (E) of paragraph (2) of this subsection.

(b) An individual's coverage period shall continue until his enrollment has been terminated—

(1) by the filing of notice that the individual no longer wishes to participate in the insurance program established by this part, or

(2) for nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall (*except as otherwise provided in section 1843(e)* take effect at the close of the calendar quarter following the calendar quarter in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period in which overdue premiums may be paid and coverage continued. The grace period determined under the preceding sentence shall not exceed 90 days; except that it may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period.

Where an individual who is deemed to have enrolled for medical insurance pursuant to section 1837(f) files a notice before the first day of the month in which his coverage period begins advising that he does not wish to be so enrolled, the termination of the coverage

period resulting from such deemed enrollment shall take effect with the first day of the month the coverage would have been effective and such notice shall not be considered a disenrollment for the purposes of section 1837(b). Where an individual who is deemed enrolled for medical insurance benefits pursuant to section 1837(f) files a notice requesting termination of his deemed coverage in or after the month in which such coverage becomes effective, the termination of such coverage shall take effect at the close of the calendar quarter following the calendar quarter in which the notice is filed.

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a) * * *

* * * * * * *

(d) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (b) or (c) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled; *except that in no case may the total amount of such increase exceed 30 percent of such monthly premium so determined.* For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual [who enrolls for a second time) (2) the months which elapsed between the date of the termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time] *who reenrolls*) *(2) the months which elapsed between the date of termination of a previous coverage period and the month after the month in which he reenrolled.* Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

* * * * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

(b)(1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided *in paragraph (6) of this subsection or* in section 1870(f)) be made—

(i) * * *

* * * * * * *

(5) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

(6) No such contract shall provide for payment for a second or third opinion described in section 1833(a)(1)(G) on a basis other than that described in clause (ii) of paragraph (3)(B).

(h) If a physician's bill or request for payment for a physician's services includes a charge to a patient for a laboratory test for which payment may be made under this part, the amount payable with respect to the test shall be determined as follows:

* * * * * * *

(1) If the bill or request for payment indicates that the physician who submitted the bill or for whose services the request for payment was made personally performed or supervised the per-

formance of the test or that another physician with whom the physician shares his practice personally performed or supervised the test, the payment shall be the reasonable charge for the test (less the applicable deductible and coinsurance amounts).

(2) If the bill or request for payment indicates that the test was performed by a laboratory, identifies the laboratory, and indicates the amount the laboratory charged the physician who submitted the bill or for whose services the request for payment was made, payment for the test shall be the lower of—

(A) the laboratory's reasonable charge to individuals enrolled under this part for the test, or

(B) the amount the laboratory charged the physician for the test,

plus a nominal fee (where the physician bills for such a service) to cover the physician's costs in collecting and handling the sample on which the test was performed (less the applicable deductible and coinsurance amounts).

(3) If the bill or request for payment (A) does not indicate who performed the test, or (B) indicates that the test was performed by a laboratory but does not identify the laboratory or include the amount charged by the laboratory, payment shall be the lowest charged at which the carrier estimates the test could have been secured by a physician from a laboratory serving the locality (less the applicable deductible and coinsurance amounts).

STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS (OR ARE ELIGIBLE FOR MEDICAL ASSISTANCE)

SEC. 1843. (a) * * *

* * * * * * *

(e) Any individual whose coverage period attributable to the State agreement is terminated pursuant to subsection (d)(3) shall be deemed for purposes of this part (including the continuation of his coverage period under this part) to have enrolled under section 1837 in the initial general enrollment period provided by section 1837(c). *The coverage period under this part of any such individual who (in the last month of his coverage period attributable to the State agreement or in any of the following six months) files notice that he no longer wishes to participate in the insurance program established by this part, shall terminate at the close of the month in which the notice is filed.*

* * * * * * *

(g)(1) The Secretary shall, at the request of a State made before January 1, 1970, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

(2) In the case of any individual who would (but for this subsection) be excluded from the applicable coverage group described in subsection (b) by the second sentence of such subsection—

(A) subsections (c) and (d)(2) shall be applied as if such subsections referred to the modification under this subsection (in lieu of the agreement under subsection (a)), *and*

(B) subsection (d)(3)(B) shall not apply so long as there is in effect a modification entered into by the State under this subsection [, and].

[(C) notwithstanding subsection (e), in the case of any termination described in such subsection, such individual may terminate his enrollment under this part by the filing of a notice, before the close of the third month which begins after the date of such termination, that he no longer wishes to participate in the insurance program established by this part (and in such a case, the termination of his coverage period under this part shall take effect as of the close of such third month.)]

* * * * * * *

Part C—Miscellaneous Provisions

Definition of Service, Institutions, Etc.

Sec. 1861. For purposes of this title—

Spell of Illness

(a) * * *

Inpatient Hospital Services

(b) The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) * * *

* * * * * * *

[(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), unless (A) such inpatient is a private patient (as defined in regulations), or (B) the hospital establishes that during the two-year period ending December 31, 1967, and each year thereafter all inpatients have been regularly billed by the hospital for services rendered by physicians and reasonable efforts have been made to collect in full from all patients and payment of reasonable charges (including applicable deductibles and coinsurance) has been regularly collected in full or in substantial part from at least 50 percent of all inpatients.]

(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.

* * * * * * *

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f) and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and [subsections (i) and (n)] *subsection (i)* of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff or physicians;

(4) has a requirement that every patient must be under the care of a physician;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that--

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individual, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of the individuals who are furnished services in the institution.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determina-

tion of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1814(f)(2), and [subsections (i) and (n)] *subsection (i)* of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r) to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g)) or unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. *The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—*

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

(B) with respect to the health and safety requirements promul-

gated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, and (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary may (i) waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

* * * * * * *

Post-Hospital Extended Care Services

(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility—

(A) within [14] *30* days after discharge from such hospital [, or (B) within 28 days after such discharge, in the case of an individual who was unable to be admitted to a skilled nursing facility within such 14 days because of a shortage of appropriate bed space in the geographic area in which he resides, or (C)], *or (B)* within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within [14] *30* days after discharge from a hospital;

an individual shall be deemed not to have been discharged from a skilled nursing facility if, within [14] *30* days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

* * * * * * *

[redacted]

Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) * * *

* * * * * * *

(13) meets such provisions of [the Life Safety Code of the National Fire Protection Association (23d edition, 1973) as are applicable to nursing homes; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients] *such edition (as specified by the Secretary in regulations) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes*; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities;

* * * * * * *

Utilization Review

(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made either (A) a staff committee of the institution composed of two or more physicians (*of which at least two must be physicians described in subsection (r)(1) of this section*), with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

* * * * * * *

Agreements for Transfer Between Skilled Nursing Facilities and Hospitals

(l) A hospital and a skilled nursing facility *or community mental health center* shall be considered to have a transfer agreement in effect

if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

(1) transfer of patients will be effected betwen the hospital and the skilled nursing facility *or community mental health center* whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility *or community mental health center* which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of the patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physican;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide *who has successfully completed a training program approved by the Secretary;*

* * * * * * *

[Post-Hospital Home Health Services

[(n) The term "post-hospital home health services" means home health services furnished an individual within one year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within one year after his most

recent discharge from a skilled nursing facility of which he was an inpatient entitled to payment under part A for post-hospital extended care services, but only if the plan covering the homes health services (as described in subsection (m)) is established within 14 days after his discharge from such hospital or skilled nursing facility.]

Home Health Agency

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(5) has in effect an overall plan and budget that meets the requirements of subsection (z); [and]

(6) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization; *and*

(7) *meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program;*

[except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations; and] except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

* * * * * * *

Physicians' Services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation (*including consultation as to the necessity and appropriateness of elective surgical procedures*), and home, office, and institutional calls (but not including services described in subsection (b)(6)).

Physician

(r) The term "physician," when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of [dentistry or of dental or oral surgery] *dental surgery or of dental medicine* who is legally authorized to practice dentistry by the State in which he performs such function [but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone, or (C) the certification required by section 1814(a)(2)(E) of this Act] *and who is acting within the scope of his license when he performs such functions*, [(3) except for the purposes of section 1814(a), section 1835, and subsections (j), (k), (m), and (o) of this section a doctor of podiatry or surgical chiropody, but (unless clause (1) of this subsection also applies to him) only with respect to functions which he is legally authorized to perform as such by the State in which he performs them,] *(3) a doctor of podiatric medicine for the purposes of subsection (s) of this section but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them; and for the purposes of subsections (k) and (m) of this section and sections 1814(a) and 1835 but only if his performance of functions under subsections (k) and (m) and sections 1814(a) and 1835 is consistent with the policy of the institution or agency with respect to which he performs them and with the functions which he is legally authorized to perform*, [or] (4) a doctor of optometry, who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to [establishing the necessity for prosthetic lenses] *services related to the treatment of aphakia*, [or] (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray *or other chiropractic clinical findings* to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided, *or (6) a clinical psychologist who is licensed as such by the State (or in a State which does not license clinical psychologists as such, is legally authorized to perform the services of a clinical psychologist in the jurisdiction in which he performs such services) and who meets uniform minimum requirements prescribed by the Secretary, but only for the purpose of section 1861(s)(1) and section 1835(a)(2)(B)(ii) and only with respect to the treatment of an individual who is not an inpatient of a hospital (as defined in subsection (e) or (f) of this section), was referred to the psychologist by a physician described in clause (1) and is receiving such services in connection with the treatment of mental psychoneurotic, or personality disorders and only with*

respect to services which such clinical psychologist is legally authorized to perform by the State or jurisdiction in which such services are furnished. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services;

(E) rural health clinic services; [and]

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician; and

(H) services furnished pursuant to a contract under section 1876 to a member of a health maintenance organization by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

(3)(A) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such

conditions relating to health and safety as the Secretary may find necessary), diagnostic laboratory tests, and other diagnostic tests;

(B) diagnostic X-ray tests which are furnished by a physician described in subsection (r)(5) and which are reasonable and necessary in the diagnosis of a subluxation of the spine;

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(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care) including replacement of such devices; [and]

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition[.] *; and*

(10) pneumococcal vaccine and its administration.

No diagnostic tests performed in any laboratory which is independent of a physician's office, a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

[(10)] *(11)* if situated in any State in which State or applicable local law provides for licensing of establishments of this nature (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

[(11] *(12)* meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which—

[(12)] *(13)* would not be included under subsection (b) if it were furnished to an inpatient of a hospital; or

[(13)] *(14)* is furnished under arrangements referred to in such paragraph (2)(C) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.

None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

* * * * * * *

Provider of Services

(u) The term "provider of services" means a hospital, *ambulatory surgical center*, skilled nursing facility, *comprehensive outpatient rehabilitation facility*, home health agency, *community mental health center*, or, for purposes of section 1814(g) and section 1835(e), a fund.

Reasonable Cost

(v)(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, [and] (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excesssive, *and (iii) take into account the customary practices of providers of services in the replacement of blood (or equivalent quantities of packed red blood cells, as defined in regulations) furnished to an individual with respect to whom payment may be made under this title, except that, notwithstanding such practices, such adjustments as are necessary to assure compliance with the principles set forth in this subsection (and regulations pursuant thereto) shall be made in determining such costs.*

* * * * * * *

(G) In determining such reasonable cost with respect to home health agencies, the Secretary may not include—

(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of the financial security requirement described in subsection (o)(7);

(ii) in the case of home health agencies to which the financial security requirement described in subsection (o)(7) applies, any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this title to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

(iii) in the case of contracts entered into by a home health agency after the date of enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract (I) which is entered into for a period exceeding five years, or (II) which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency; and

(iv) in the case of contracts entered into by a home health agency before the date of enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract, which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency, to the extent that such cost exceeds the reasonable value of the services furnished on behalf of such agency.

(H) In determining such reasonable cost, the Secretary may not include any costs incurred by a provider with respect to any service furnished in connection with matters for which payment may be made under this title and furnished pursuant to a contract between the provider and any of its subcontractors which is entered into after the date of enactment of this subparagraph and the value or cost of which is $10,000 or more over a twelve-month period unless the contract contains a clause to the effect that until the expiration of three years after the furnishing of such services pursuant to such contract, the subcontractor shall make available, upon request, to the Secretary or the Comptroller General of the United States (or any of their duly authorized representatives) the contract, and books, documents, and records of such subcontractor that are necessary to verify the nature and extent of such costs.

(I) Where a hospital furnishes inpatient services that would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility on the basis of a determination made by a Professional Standards Review Organization (or, in the absence of such a qualified organization, by such organization or agency with review responsibility as is otherwise provided for under this title) that (i) post-hospital extended care services are medically necessary;

and (ii) such services are not otherwise available (as determined in accordance with criteria established by the Secretary) at the time the determination is made that post-hospital extended care services rather than inpatient hospital services are medically necessary (and for such period as the circumstances described in clauses (i) and (ii) continue to apply); and where the Secretary finds that such hospital (I) has had, during the immediately preceding calendar year, an average daily occupancy rate of less than 80 percent, and (II) could be granted a certificate of need for the provision of long-term care services from the designated State health planning and development agency for the State in which the hospital is located, the reasonable cost of such services for such hospital shall be computed as provided for in section 1884(a). Where payment is made in accordance with the preceding sentence, the individual who is furnished such services will be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

Arrangements for Certain Services

(w)(1) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, a skilled nursing facility, *community mental health center*, or home health agency (whether in its own right or as agent) with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

* * * * * * *

Institutional Planning

(z) An overall plan and budget of a hospital, [extended care facility,] *skilled nursing facility, comprehensive outpatient rehabilitation facility*, or home health agency shall be considered sufficient if it—

(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget an item-by-item identification of the components of each type of anticipated expenditure or income);

(2) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in subparagraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would under generally accepted accounting principles, be considered capital items;

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff and the medical staff (if any) of the institution or agency.

* * * * *

RURAL HEALTH CLINIC SERVICES

(aa) (1) The term "rural health clinic services" means—

(A) physicians' services and such services and supplies as are covered under section 1861(s)(2)(A) if furnished as an incident to a physician's professional service *and items and services described in section 1861(s)(10);*

(B) such services furnished by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

(C) in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician described in paragraph (2)(B),

when furnished to an individual as an outpatient of a rural health clinic.

(2) The term "rural health clinic" means a facility which—

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians or physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and ad-

mission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services,

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has appropriate procedures for review of utilization of clinic services to the extent that the Secretary determines to be necessary and feasible; and

(J) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and that is designated by the Secretary either (I) as an area with a shortage of personal health services under section 1302(7) of the Public Health Service Act or (II) as a health manpower shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsuarnce amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistance or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause.

Physician Assistant and Nurse Practitioner

[(3)] (*bb*) The term "physician assistant" and the term "nurse practitioner" mean[, for the purposes of paragraphs (1) and (2),] a

physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

Community Mental Health Center Services

(1) The term "community mental health center services" means the following items and services furnished to an individual as an outpatient by a community mental health center or (to the extent permitted in regulations by the Secretary) by others under arrangements with them made by the center—

(A) diagnostic, therapeutic, or rehabilitative services furnished at the facility and crisis intervention outside the facility, when furnished by a physician (as defined in subsection (r)(1)) or any qualified mental health professional (as defined by the Secretary in regulations), including clinical psychologists, psychiatric nurses, and psychiatric social workers;

(B) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered; and

(C) such items and supplies as are ordinarily furnished to outpatients by community mental health centers in connection with an active mental health program of diagnosis and treatment,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

(2) The term "community mental health center" means a facility which—

(A) meets the definition of a community mental health center under section 201 of the Community Mental Health Centers Act and the regulations prescribed thereunder;

(B) has a requirement that all mental health services are provided under the supervision of a physician or other qualified mental health professional;

(C) meets such requirements as the Secretary may prescribe with respect to staffing requirements and qualifications of the staff;

(D) maintains clinical records on all patients;

(E) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(F) has in effect an agreement with a hospital pursuant to subsection (l);

(G) in the case of a community mental health center in any State in which State or applicable local law provides for the licensing of community mental health centers, is licensed pursuant to such law;

(H) has appropriate procedures or arrangements (in compliance with applicable State and Federal law) for storing, administering, and dispensing drugs and biologicals; and

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such center.".

Comprehensive Outpatient Rehabilitation Facility Services

(dd)(1) The term "comprehensive outpatient rehabilitation facility services" means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

(A) physicians' services;

(B) physical therapy, occupational therapy, speech pathology service, and respiratory therapy;

(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic an orthotic devices;

(D) social and psychological services;

(E) nursing care provided by or under the supervision of a registered professional nurse;

(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self administered;

(G) supplies, appliances, and equipment, including the purchase or rental of equipment; and

(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an outpatient of a hospital.

(2) The term "comprehensive outpatient rehabilitation facility" means a facility which—

(A) is primarily engaged in providing (by or under the supersion of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilation of injured, disabled, or sick persons;

(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services rendered by physicians, as defined in section 1861(r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

(C) maintains clinical records on all patients;

(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

(E) has a requirement that every patient must be under the care of a physician;

(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standard establishment for such licensing;

(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(H) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, *or, in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness*;

* * * * * * *

(7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefore, or immunizations *(except as otherwise allowed under section 1861(s)(10) and paragraph (1))*;

* * * * * * *

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status, *or because of the severity of the dental procedure*, requires hospitalization in connection with the provision of such services; or

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supporting devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns[, warts,] or calluses, the trimming of nails, and other routine hygienic care).

(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State *or under an automobile insurance policy*. Any payment under this title with re-

spect to any item or services shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan *or policy.*

* * * * * * *

[(e) (1) Whenever the Secretary determines that a physician or other individual practitioner has been convicted (on or after the date of the enactment of this subsection, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such physician's or practitioner's involvement in the programs under this title or the program under Title XIX, the Secretary shall suspend such physician or practitioner from participation in the program under this title for such period as he may deem appropriate; and no payment may be made under this title with respect to any item or service furnished by such physician or practitioner during the period of such suspension. The provisions of paragraphs (2) and (3) of subsection (d) shall apply with respect to determinations made by the Secretary under this subsection.

[(2) In any case where the Secretary under paragraph (1) suspends any physician or other individual practitioner from participation in the program under this title, he shall—

[(A) promptly notify each single State agency which administers or supervises the administration of a State plan approved under title XIX of the fact, circumstances, and period of such suspension; and

[(B) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such physician or practitioner of the fact and circumstances of such suspension, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health, Education, and Welfare fully and currently informed with respect to any actions taken in response to such request.]

(e) No payment may be made under this title with respect to any item or service furnished by a physician or other individual during the period when he is barred pursuant to section 1127 from participation in the program under this title.

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CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

SEC. 1863. In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(9), (f)(4), (g)(4), (j)(11), and (o)(6) *(o)(6), and (dd)(2)(I)* of section 1861, the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1867, appropriate State agencies, and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be

varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under Title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

SEC. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2), *or a comprehensive outpatient rehabilitation facility as defined in section 1861(dd)(2)*, or whether a laboratory meets the requirements of paragraphs [(10)] *(11)* and [(11)] *(12)* of section 1861(s), or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p)(4), *or whether a facility therein is a community mental health center as defined in section 1861(cc)(2)*. To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, or home health agency, *or a community mental health center* (as those terms are defined in section 1861) may be treated as such by the Secretary. [Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement.] Within 90 days following the completion of each survey of any health care facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, laboratory, *community mental health center*, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, laboratory, *community mental health center*, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major addition conditions which the Secretary finds necessary in

the interest of health and safety of individuals who are furnished care or services by any such health care facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, laboratory, *community mental health center*, clinic, agency, or organization.

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AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

* * * * * * *

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1) or (a)(3), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). [In the case of items and services described in section 1833 (c), clause (ii) of the preceding sentence shall be applied by substituting for 20 per centum the proportion which is appropriate under such section.]

* * * * * * *

[(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1813(a)(2) (except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined) and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, so as defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf.

[For purposes of subparagraph (C), whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1813 (a)(2).]

* * * * * * *

(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or

which has been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under Title XIX of this Act to deny payment under Title XIX) with respect to any individual admitted to such facility after a date specified by him.

(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of section 1861(j) on the date specified in such clause, the Secretary shall terminate such facility's agreement or provide for termination of such facility's certification, notwithstanding the provisions of paragraph (2) of subsection (b) effective with the first day of the first month following the month specified in such clause.

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OVERPAYMENTS ON BEHALF OF INDIVIDUALS AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BEHALF OF DECEASED INDIVIDUALS

SEC. 1870. (a) * * *

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[(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and—

[(1) no assignment of the right to payments was made by such individual before his death, and

[(2) payment for such services has not been made,

payment for such services shall be made to the physician or other person who provided such services, but payment shall be made under this subsection only in such amount and subject to such con-

ditions as would have been applicable if the individual who received the services had not died, and only if the person or persons who provided the services agrees that the reasonable charge is the full charge for the services.]

(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and no assignment of the right to payment for such services was made by such individual before his death, and payment for such services has not been made—

(1) if the person or persons who furnished the services agree that the reasonable charge is the full charge for the services, payment for such services shall be made to such person or persons, and

(2) if the person or persons who furnished the services do not agree that the reasonable charge is the full charge for the services, payment for such services shall be made on the basis of an itemized bill to the person who has agreed to assume the legal obligation to make payment for such services and files a request for payment (with such accompanying evidence of such legal obligation as may be required in regulations),

but only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.

* * * * * * *

[PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

[SEC. 1876. (a)(1) In lieu of amounts which would otherwise be payable pursuant to sections 1814(b) and 1833(a), the Secretary is authorized to determine, by actuarial methods, as provided in this section, but only with respect to a health maintenance organization with which he has entered into a contract under subsection (i), a per capita rate of payment—

[(A) for services provided under parts A and B for individuals enrolled with such organization pursuant to subsection (e) who are entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B, and

[(B) for services provided under part B for individuals enrolled with such organization pursuant to subsection (e) who are not entitled to benefits under part A but who are enrolled for benefits under Part B.

[(2) An interim per capita rate of payment for each health maintenance organization shall be determined annually by the Secretary on the basis of each organization's annual operating budget and enrollment forecast which shall be submitted (in such form and in such detail as the Secretary may prescribe) at least 90 days before the beginning of each contract year. Each interim rate shall be equal to the estimated per capita cost (based upon types and components of expenses otherwise reimbursable under this title) of providing services defined in paragraph (3)(A)(iii). In the event that the data requested to be furnished by a health maintenance organization are not furnished timely, such reduction in interim payments may be made by the Secretary as is appropriate, until such time as a reasonable esti-

PENALTIES

SEC. 1877. (a) * * *

(b)(1) Whoever *knowingly and willfully* solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever *knowingly and willfully* offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

* * * * * * *

PROVIDER REIMBURSEMENT REVIEW BOARD

SEC. 1878. (a) * * *

* * * * * * *

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. *Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which such determination is rendered. If a*

provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205.

* * * * * * *

LIMITATION ON LIABILITY OF BENEFICIARY WHERE MEDICARE CLAIMS ARE DISALLOWED

SEC. 1879. (a) * * *

* * * * * * *

(e) Where payment for inpatient hospital services or extended care services may not be made under part A of this title on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of sections 1861 (e) or (j) by such a provider of services acting in good faith in accordance with the advice of a utilization review committee, professional standards review organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary shall take such action with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertent, or erroneous action.

* * * * * * *

MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

SEC. 1881. (a) * * *

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(c)(1)(A) * * *

* * * * * * *

(4) The Secretary shall, in determining whether to certify additional facilities or expansion of existing facilities within a network, take into account the network's goals and performance as reflected in the network's annual report. *The Secretary may not find, for purposes of such certification, that the addition or expansion of a facility within a network is not needed if the State health planning and develop-*

ment agency, fully or conditionally designated under Title XV of the Public Health Service Act for the State in which the facility is located, has certified under section 1523(a)(4)(B) of such Act that such addition or expansion is needed.

* * * * * * *

(e)(1) Notwithstanding any other provision of this title, the Secretary may, pursuant to agreements with approved providers of services [and], renal dialysis facilities, *and nonprofit entities which the Secretary finds can furnish equipment economically and efficiently*, reimburse such providers [and facilities], *facilities, and nonprofit entities* (without regard to the deductible and coinsurance provisions of this title) for the reasonable cost of the purchase, installation, maintenance and reconditioning for subsequent use of artificial kidney and automated dialysis peritoneal machines (including supportive equipment) which are to be used exclusively by entitled individuals dialyzing at home.

(2) An agreement under this subsection shall require that the provider [or facility will], *facility, or other entity will*—

(A) make the equipment available for use only by entitled individuals dialyzing at home;

(B) recondition the equipment, as needed, for reuse by such individuals throughout the useful life of the equipment, including modification of the equipment consistent with advances in research and technology;

(C) provide for full access for the Secretary to all records and information relating to the purchase, maintenance, and use of the equipment; and

(D) submit such reports, data, and information as the Secretary may require with respect to the cost, management, and use of the equipment.

* * * * * * *

(g) The Secretary shall submit to the Congress on [April] *July* 1, 1979, and [April] *July* 1 of each year thereafter a report on the end stage renal disease program, including but not limited to—

(1) the number of patients, nationally and by renal disease network, on dialysis (self-dialysis or otherwise) at home and in facilities;

(2) the number of new patients entering dialysis at home and in facilities during the year;

(3) the number of facilities providing dialysis and the utilization rates of those facilities;

(4) the number of kidney transplants, by source of donor organ;

(5) the number of patients awaiting organs for transplant;

(6) the number of transplant failures;

(7) the range of costs of kidney acquisitions, by type of facility and by region;

(8) the number of facilities providing transplants and the number of transplants performed per facility;

(9) patient mortality and morbidity rates;

(10) the average annual cost of hospitalization for ancillary problems in dialysis and transplant patients, and drug costs for transplant patients;

(11) medicare payment rates for dialysis, transplant procedures, and physician services, along with any changes in such rates during the year and the reasons for those changes;

(12) the results of cost-saving experiments;

(13) the results of basic kidney disease research conducted by the Federal Government, private institutions, and foreign governments;

(14) information on the activities of medical review boards and other networks organizations; and

(15) estimated program costs over the next five years.

INTERNATIONAL AGREEMENTS

SEC. 1883. (a) The President is authorized to enter into agreements establishing reciprocal arrangements between the programs established by this title and the program of any foreign country under which similar services are provided directly to entitled individuals or under which insurance is provided to meet all or part of the expenses of entitled individuals for such services.

(b) Any agreement establishing such a reciprocal arrangement pursuant to this section shall specify—

(1) the nature and extent of payment to be made to or on behalf of (A) individuals entitled to benefits under this title for services covered under such title when such individuals are present in the foreign country and receive such services from persons who are authorized under the program of that foreign country to furnish them, and (B) individuals entitled to benefits under the program of that foreign country who receive such services in the United States from persons meeting such requirements or conditions as are required under such title;

(2) such limitations on the nature and duration of services for which payment may be made in one country to individuals entitled to benefits under the program of the other country, as the President deems appropriate, except that no agreement shall authorize any individual to receive benefits in the United States on a reciprocal basis in excess of those provided for individuals entitled to benefits under this title;

(3) such limitations on entitlement of individuals to benefits on a reciprocal basis under an agreement in the United States and in the foreign country, as the President deems appropriate, except that no agreement shall provide entitlement to benefits under this title in the United States for an individual who does not meet the requirements for entitlement applicable under such title with respect to age or medical condition;

(4) the methods by which the cost of providing services to persons on a reciprocal basis shall be shared equitably by the persons receiving such services and by the respective programs of the United States and the foreign country; and

(5) such other provisions not inconsistent with this section, as the President deems appropriate.

(c) The Secretary shall make rules and regulations and establish procedures which are reasonable and necessary to implement and ad-

minister any agreement which has been entered into in accordance with this section.

(d) Pending the conclusion of an agreement under this section with a foreign country, the Secretary is authorized to enter into interim arrangements with any hospital in that country which is accredited by the Joint Commission on Accreditation of Hospitals, or such other hospitals as the Secretary finds meet health and safety standards equivalent to those required under this title for hospitals in the United States and which are accredited in the foreign country concerned, under which payment may be made for inpatient hospital services, as defined in section 1861, to or on behalf of an individual who is entitled to such benefits under part A of this title. For purposes of making payment under such an interim arrangement, the Secretary shall use whichever of the methods provided for in section 1814(f) he finds appropriate, except that any payments made under part A of this title to the individual or to the hospital shall be reduced to the extent that the individual has no legal obligation to pay for any items or services furnished to such individual by reason of the laws of the foreign country in which the hospital is located or such individual's membership in an insurance plan that provides for payment for such items or services.

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

SEC. 1884. (a)(1) Any hospital (other than a hospital which has in effect a waiver of the requirement imposed by section 1861(e)(5)) which has an agreement under section 1866 may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute post-hospital extended care services.

(2)(A) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this section shall be based upon the reasonable cost of the services as determined under subparagraph (B).

(B)(i) The reasonable cost of the services consists of the reasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services (determined under clause (iii)).

(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this section is equal to the product of (I) the number of patient-days during the year for which the services were furnished, and (II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the previous calendar year under Title XIX to skilled nursing facilities located in the State in which the hospital is located and which have agreements entered into under section 1902(a)(28).

(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(b) The Secretary may not enter into an agreement under this section with any hospital unless the hospital has been granted a certificate of need for the provision of long-term care services from the State

health planning and development agency (designated under section 1521 of the Public Health Service Act) for the State in which the hospital is located.

(c) An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866 (unless the hospital fails to satisfy the requirements specified in subsection (b)) and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866, or where there is in effect for the hospital a waiver of the requirement imposed by section 1861(e)(5). A hospital whose agreement under this section has been terminated shall not be eligible to undertake a new agreement until a two-year period has elapsed from the termination date.

(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

(e) During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement received for routine services from all classes of long-term care patients (including XVIII, Title XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine Title XVIII reimbursement for routine hospital services.

(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

(g) The Secretary shall prescribe by regulation an alternative method for determining the amount of the reasonable cost of post-hospital extended care services furnished in a distinct part of a hospital certified as a skilled nursing facility under section 1861(j) that

is the same method as the method described in subsections (a) and (e) for determining the amount of the reasonable cost for such services furnished by a hospital that uses beds interchangeably for either acute or long-term care and shall approve the use of this method when a hospital can demonstrate that its use would contribute significantly to the more efficient or effective administration of this part and would be in the interest of program beneficiaries.

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

Sec. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(9) provide—

(A) that the State health agency or other appropriate State medical agency (whichever is utilized by the Secretary for the purposes specified in the first sentence of section 1864(a)), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or service, [and]

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions[;], *and*

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the requirements of section 1861(e)(9) or paragraphs (10) and (11) of section 1861(s);

* * * * * * *

(13) provide—

(A)(i) for the inclusion of some institutional and some noninstitutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under Title I, X, XIV, or XVI, or part A of Title IV, or with respect to whom supplemental security income benefits are being paid under Title XVI, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1905(a), and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1905(a) or

(ii)(I) the care and services listed in any 7 of the clauses numbered (1) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such facility, and

(D) for payment (*except where the State agency is subject to an order under section 1913*) of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for the purposes of Title XVIII, *except that in the case of hospitals reimbursed for services under part A of Title XVIII in accordance with section 1814(b)(2), the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section;* and

(E) effective July 1, 1976, for payment (*except where the State agency is subject to an order under section 1913*) of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary; and

* * * * * * *

(23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provided that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a pre-payment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) (A) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic, *or* (*B*) *during the three-year period beginning on the later*

of October 1, 1980, or the date of the enactment of this clause, has made arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3), if the Secretary has found that (i) adequate services will be available under such arrangements, (ii) such laboratory services will be provided only through laboratories (I) which meet the requirements of the section 1861(e)(9) or paragraphs (10) and (11) of section 1861(s), and such additional requirements as the Secretary may require, (II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefits under this title or under part A or part B of Title XVIII, and (iii) charges for services provided under such arrangements are made at the lowest rate charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such services) for comparable services by the provider of such services, or, if charged for on a unit price basis, such charges result in aggregate expenditures not in excess of expenditures that would be made if charges were at the lowest rate charged for comparable services by the provider of such services;

* * * * * * *

(33) provide—

(A) that the State health agency, or other appropriate state medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the penultimate sentence of this subsection; and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, *except that the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;*

* * * * * * *

[(35) provide that any intermediate care facility receiving payments under such plan complies with the requirements of section 1124;]

(35) provide that any disclosing entity (as defined in section 1124(a)(2)) receiving payments under such plan complies with the requirements of section 1124;

* * * * * * *

[(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of the State plan is notified by the Secretary under section 1862(a)(2)(A) that a physician or other individual practitioner has been suspended from participation in the program under title XVIII, the agency shall promptly suspend such physician or practitioner from participation in the plan for not less than the period specified in such notice, and no payment may be made under the plan with respect to any item or service furnished by such physician or practitioner during the period of the suspension under this title;]

(39) provide that the State agency shall bar any specified individual from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1127, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization; [and]

(41) provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary of such action [.];

(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1128(a); and

(43) if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician (or any other physician with whom he shares his practice) did not personally perform or supervise, include provision to insure that payment under the State plan for such laboratory services not exceed the payment authorized for such services by section 1842(h).

* * * * * * *

[(g) The Secretary may waive suspension under subsection (a)(39) of a physician's or practitioner's participation in a State plan approved under this title and of the prohibition under such subsection of payment for any item or service furnished by him during the period of such suspension, if the single State agency which administers or supervises the administration of the plan submits a request to the Secretary for such waiver and if the Secretary approves such request.]

(h)(1) In addition to any other authority under State law, where a State determines that a skilled nursing facility or intermediate care facility which is certified for participation under its plan or longer substantially meets the provisions of section 1861(j) or section 1905(c), respectively, and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j) or section 1905(c) (as the case may be), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j) or section 1903(c) (as the case may be), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

PAYMENTS TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) [and

(h)], (*h*), *and* (*j*) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under Title I, X, XIV, XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under Title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII or who are not enrolled under part B of Title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof); plus

* * * * * * *

(7) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the performance of a second or third opinion as to necessity and appropriateness of specified elective surgical procedures in the case of a demonstration project described in section 1129(f)(1)(B); plus

[(7)](*8*) *an amount equal to 50 per centum of the remainder of the amounts expended such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.*

* * * * * * *

(i) Payment under the preceding provisions of this section shall not be made—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth [and fifth], *fifth, and ninth* sentences of section 1842(b)(3); or

* * * * * * *

[(j)(1) Notwithstanding the preceding provisions of this section, no payment shall be made to a State (except as provided under this subsection) with respect to expenditures incurred by it for services provided by any institution during any period that an order for suspension of payment (as authorized by this subsection) is effective with respect to such institution.

[(2) The Secretary may issue a suspension of payment order with respect to any institution if—

[(A) such institution (i) does not (at the time such order is issued) have in effect an agreement with the Secretary which is entered into pursuant to section 1866; and (ii) did (prior to the time such order is issued) have in effect such an agreement; and

[(B)(i) The Secretary has been unable to collect (or make satisfactory arrangement for the collection of) amounts due on account of overpayments made to such institution under Title XVIII; or

[(ii) the Secretary has been unable to obtain from such institution the data and information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under Title XVIII.

[(3) Whenever the Secretary issues any order for suspension of payment under this subsection with respect to any institution, he shall submit a notice of such order to the single State agency (referred to in section 1902(a)(5)) of each State which he has reason to believe does or may utilize the services of such institution in providing medical assistance under a plan approved under this title.

[(4) Any order for suspension of payment issued with respect to any institution under this subsection shall become effective, in the case of any State plan approved under this title, on the 60th day after the date the State agency (referred to in section 1902(a)(5)) administering or supervising the administration of such plan receives notice of such order submitted pursuant to paragraph (3). Any such order shall cease to be effective at such time as the Secretary is satisfied that the institution is participating in substantial negotiations which seek to remedy the conditions which gave rise to his order of suspension of payments, or that the amounts (referred to in paragraph (2)) are no longer due from such institution or that a satisfactory arrangement has been made for the payment by such institution of any such amounts. Upon the determination of the Secretary that any such order with respect to any such institution shall cease to be effective, he shall forthwith notify each State agency to which he has theretofore submitted notice under paragraph (3) with respect to such institution.

[(5) Whenever any order which has been issued by the Secretary under the preceding provisions of this subsection with respect to an institution ceases to be effective, any payment to which any State would (except for the preceding provisions of this subsection) have been entitled under this section on account of services provided by such institution shall be made to such State for the month in which such order ceases to be effective.]

(j) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1913.

* * * * * * *

(n) The State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organization, or agency for purposes of participation under the State plan, or otherwise to approve an institution, organization, or agency for such purposes, if any person, who has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such institution, organization, or agency, is a person described in section 1126(a) (whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1866 [or is subject to a suspension of payment order issued under subsection (j)] of this section; and, notwithstanding any other provision of this section, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization,

or agency did not fully and accurately make any disclosure required of it by section 1126(a) at the time such contract or agreement was entered into or such approval was given.

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CERTIFICATION AND APPROVAL OF SKILLED NURSING FACILITIES AND OF RURAL HEALTH CLINICS

Sec. 1910. (a) * * *

* * * * * * *

(c)(1) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and Title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

(2) Any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.

WITHHOLDING OF FEDERAL SHARE OF PAYMENTS FOR CERTAIN MEDICARE PROVIDERS

SEC. 1913. (a) The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for medical assistance for care or services furnished in any quarter by—

(1) an institution (A) which has or previously had in effect an agreement with the Secretary under section 1866; and (B)(i) from which the Secretary has been unable to recover overpayments made under Title XVIII, or (ii) from which the Secretary

has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under Title XVIII; and

(2) any person (A) who (i) has previously accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii), and (ii) during the annual period immediately preceding such quarter submitted no claims for payment under Title XVIII, or submitted claims for payment under Title XVIII which aggregated less than the amount of overpayments made to him, and (B)(i) from whom the Secretary has been unable to recover overpayments received in violation of the terms of such assignment, or (ii) from whom the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such person under Title XVIII.

(b) The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this title for any quarter by an amount equal to the lesser of the Federal matching share of payments to any institution or person specified in subsection (a), or the total overpayments to such institution or person under Title XVIII, and may require the State to reduce its payment to such institution or person by such amount.

(c) The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to an institution or person, pursuant to subsection (b) until after he has provided adequate notice (which shall be not less than 60 days) to the State agency and the institution or person.

(d) The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall (1) determine the amount of the Federal payment to which the institution or person would otherwise be entitled under this section which shall be treated as a setoff against overpayments under Title XVIII, and (2) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under Title XVIII and to which the institution or person would otherwise be entitled under this title.

(e) The Secretary shall restore to the trust funds established under sections 1817 and 1841, as appropriate, amounts recovered under this section as setoffs against overpayments under Title XVIII.

(f) Notwithstanding any other provision of this title, an institution or person shall not be entitled to recover from any State any amount in payment for medical care and services under this title which is withheld by the State agency pursuant to an order by the Secretary under subsection (b).

HOSPITAL PROVIDERS OF SKILLED NURSING AND INTERMEDIATE CARE SERVICES

SEC. 1914. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under a State plan approved under this title for skilled nursing facility services and intermediate care facility services furnished by a hospital which has in effect an agreement under section 1884.

(b)(1) Payment to any such hospital, for any skilled nursing or intermediate care facility services furnished, shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under this title to skilled nursing and intermediate care facilities located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(2) With respect to any period for which a hospital has an agreement under section 1884, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services received from all classes of long-term care patients (including Title XVIII, Title XIX, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine Title XIX reimbursement for routine hospital services.

(c) The State plan may provide an alternative method for determining the amount of payment for long-term care services furnished in a distinct part of a hospital (where the conditions described in section 1884(g) are met) that is the same as the method prescribed in subsection (b) of this section for determining the amount of payment for such services furnished by a hospital that uses beds interchangeably for either acute or long-term care.

SECTION 7 OF THE RAILROAD RETIREMENT ACT OF 1974

POWERS AND DUTIES OF THE BOARD

SEC. 7. (a) * * *

* * * * * * *

(d)(1) The Board shall, for purposes of this subsection, have the same authority to determine the rights of individuals described in subdivision (2) to have payments made on their behalf for hospital insurance benefits consisting of inpatient hospital services, posthospital extended care services, [posthospital] home health services, and outpatient hospital diagnostic services (all hereinafter referred to as "services") under section 226, and parts A and C of title XVIII, of the Social Security Act as the Secretary of Health, Education, and Welfare has under such section and such parts with respect to individuals to whom such sections and such parts apply. For purposes of section 8, a determination with respect to the rights of an individual under this subsection shall, except in the case of a provider of services, be considered to be a decision with respect to an annuity.

SECTION 3 OF PUBLIC LAW 95-210

To amend titles XVIII and XIX of the Social Security Act to provide payment for rural health clinic services, and for other purposes.

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96TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
No. 96-1479

OMNIBUS RECONCILIATION ACT OF 1980

NOVEMBER 26, 1980.—Ordered to be printed

Mr. GIAIMO, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 7765]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 7765) to provide for reconciliation pursuant to section 3 of the First Concurrent Resolution on the Budget for the fiscal year 1981, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

TITLE I—SHORT TITLE AND PURPOSE

SHORT TITLE

SECTION 101. This Act may be cited as the "Omnibus Reconciliation Act of 1980".

PURPOSE

SEC. 102. It is the purpose of this Act to implement the recommendations which were made by specified committees of the House of Representatives and the Senate pursuant to directions contained in section 3 of the First Concurrent Resolution on the Budget for the fiscal year 1981 (H. Con. Res. 307, 96th Congress), and pursuant to the reconciliation requirements which were imposed by such concur-

BEST DOCUMENT AVAILABLE

Sec. 932. Preadmission diagnostic testing.
Sec. 933. Comprehensive outpatient rehabilitation facility services.
Sec. 934. Outpatient surgery.
Sec. 935. Outpatient physical therapy services.
Sec. 936. Dentists' services.
Sec. 937. Optometrists' services.
Sec. 938. Antigens.
Sec. 939. Treatment of planter warts.

Subpart II—Administrative Changes and Miscellaneous Provisions

Sec. 941. Presumed coverage provisions.
Sec. 942. Payment to providers of services.
Sec. 943. Limitation on payments to radiologists and pathologists.
Sec. 944. Physician treatment plan for speech pathology.
Sec. 945. Reenrollment and open enrollment in part B.
Sec. 946. Determination of reasonable charge.
Sec. 947. Shortened part B termination period for certain individuals whose premiums medicaid has ceased to pay.
Sec. 948. Reimbursement of physicians' services in teaching hospitals.
Sec. 949. Flexibility in application of standards to rural hospitals.
Sec. 950. Hospital transfer requirement for skilled nursing facility coverage.
Sec. 951. Certification and utilization review by podiatrists.
Sec. 952. Access to books and records of subcontractors.
Sec. 953. Medicare liability secondary where payment can be made under liability or no fault insurance.
Sec. 954. Payment for physicians' services where beneficiary has died.
Sec. 955. Provider reimbursement review board.
Sec. 956. Payment where beneficiary not at fault.
Sec. 957. Technical renal disease amendments.
Sec. 958. Studies and demonstration projects.
Sec. 959. Temporary delay in periodic interim payments.

PART C—PROVISIONS RELATING TO MEDICAID

Sec. 961. Disputed medicaid claims.
Sec. 962. Reimbursement rates under medicaid for skilled nursing and intermediate care facility services.
Sec. 963. Extension of increased funding for State medicaid fraud control units.
Sec. 964. Change in calendar quarter for which satisfactory utilization review must be shown to receive waiver of medicaid reduction.
Sec. 965. Reimbursement under medicaid for services furnished by nurse-midwives.
Sec. 966. Demonstration projects relating to the training of AFDC recipients as home health aides.

PART A—PROVISIONS RELATING TO MEDICARE AND MEDICAID

Subpart I—Provider Reimbursement Changes

NONPROFIT HOSPITAL PHILANTHROPY

SEC. 901. (a) Part A of title XI of the Social Security Act is amended by adding at the end thereof the following new section:

"NONPROFIT HOSPITAL PHILANTHROPY

"SEC. 1134. For purposes of determining, under titles V, XVIII, and XIX of this Act, the reasonable costs of services provided by nonprofit hospitals, the following items shall not be deducted from the operating costs of such hospitals:

"(1) A grant, gift, or endowment, or income therefrom, which is to or for such a hospital and which has not been designated by the donor for paying any specific operating costs.

"(2) A grant or similar payment which is to such a hospital, which was made by a government entity, and which is not available under the terms of the grant or payment for use as operating funds.

"(3) Those types of donor designated grants and gifts (including grants and similar payments which are made by a governmental entity), and income therefrom, which the Secretary determines, in the best interests of needed health care, should be encouraged.

"(4) The proceeds from the sale or mortgage of any real estate or other capital asset of such a hospital, which real estate or asset the hospital acquired through gift or grant, if such proceeds are not available for use as operating funds under the terms of the gift or grant.

Paragraph (4) shall not apply to the recovery of the appropriate share of depreciation when gains or losses are realized from the disposal of depreciable assets.".

(b) The amendment made by subsection (a) shall apply to grants, gifts, and endowments, and income therefrom, made or established after the date of the enactment of this Act.

REIMBURSEMENT FOR INAPPROPRIATE INPATIENT HOSPITAL SERVICES

SEC. 902. (a)(1) Section 1861(v)(1) of the Social Security Act is amended by adding at the end thereof the following new subparagraph:

"(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute post-hospital extended care services if provided by a skilled nursing facility and a Professional Standards Review Organization (or, in the absence of such a qualified organization, an organization or agency with review responsibility as is otherwise provided for under part A of title XI) determines that inpatient hospital services for the individual are not medically necessary but post-hospital extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

"(I) such post-hospital extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

"(II) inpatient hospital services for the individual are not medically necessary, and

"(III) the individual is entitled to have payment made for post-hospital extended care services under this title,

except that if the Secretary determines that the hospital had (during the immediately preceding calendar year) an average daily occupancy rate of 80 percent or more, such payment shall be made (during such period) on the basis of the reasonable cost of inpatient hospital services.

"(ii)(I) Except as provided in subclause (II), the payment rate referred to in clause (i) is a rate equal to the estimated adjusted Statewide average rate per patient-day paid for services provided in

skilled nursing facilities under the State plan approved under title XIX for the State in which such hospital is located, or, if the State in which the hospital is located does not have a State plan approved under title XIX, the estimated adjusted State-wide average allowable costs per patient-day for extended care services under this title in that State.

"(II) If a hospital has a unit which is a skilled nursing facility, the payment rate referred to in clause (i) for the hospital is a rate equal to the lesser of the rate described in subclause (I) or the allowable costs in effect under this title for extended care services provided to patients of such unit.

"(iii) Any day on which an individual receives inpatient services for which payment is made under this subparagraph shall, for purposes of this Act (other than this subparagraph), be deemed to be a day on which the individual received inpatient hospital services.

"(iv) For the purpose of determining the occupancy rate with respect to hospitals under clause (i)—

"(I) public hospitals under common ownership may elect (with the approval of the Secretary) to be treated as a single hospital, and

"(II) beginning two years after the date this subparagraph is first applied with respect to a hospital, the Secretary, to the extent feasible, shall not treat as an inpatient an individual with respect to whom payment is made to the hospital only because of this subparagraph or section 1902(h).".

(2) For amendment to section 1158(a) of the Social Security Act relating to these provisions, see section 931(h) of this title.

(3) Section 1158(d) of such Act is amended by adding at the end the following new sentence: "In the case of disapproval of inpatient hospital services where payment for inpatient services is continued under section 1861(v)(1)(G) or section 1902(h), the previous sentence shall not apply with respect to such disapproval.".

(b)(1) Section 1902(a)(13)(D) of such Act is amended—

(A) by inserting "(i)" after "(D)",

(B) by striking out the semicolon and inserting in lieu thereof a comma, and

(C) by inserting at the end thereof the following new clause:

"(ii) for payment of the reasonable cost of inappropriate inpatient services (described in subsection (h)(1)) for which payment is provided only because of subsection (h) at the rate of payment for such services provided for under such subsection.".

(2) Section 1902 of such Act is further amended by adding at the end the following new subsection:

"(h)(1) In any case in which a hospital provides inpatient services to an individual that would constitute skilled nursing facility services if provided by a skilled nursing facility or that would constitute intermediate care facility services if provided by an intermediate care facility and a Professional Standards Review Organization (or, in the absence of such a qualified organization, an organization or agency with review responsibility as is otherwise provided for under part A of title XI) determines that inpatient hospital services for the individual are not medically necessary but skilled nursing facility services or intermediate care facility services, respectively, for the individual are medically necessary and such type of facility services are not otherwise available to the individual (as determined in ac-

cordance with criteria established by the Secretary) at the time of such determination, payment for inpatient hospital services shall continue to be made under the State plan approved under this title at the payment rate described in paragraph (2) for such type of services during the period in which—

"(A) such skilled nursing facility services or intermediate care facility services (as the case may be) for the individual are medically necessary and not otherwise available to the individual (as so determined),

"(B) inpatient hospital services for the individual are not medically necessary, and

"(C) the individual is entitled to receive medical assistance with respect to such facility services under the State plan,

except that if the Secretary determines that the hospital had (during the immediately preceding calendar year) an average daily occupancy rate of 80 percent or more, such payment shall be made (during such period) on the same basis as otherwise used under the State's plan for payments for providing inpatient hospital services.

"(2)(A) Except as provided in subparagraph (B), the payment rate referred to in paragraph (1), in the case of skilled nursing facility services or intermediate care facility services, is the estimated adjusted State-wide average rate per patient-day paid for such respective type of services provided under the State plan.

"(B) If a hospital has a unit which is a skilled nursing facility or intermediate care facility, the payment rate referred to in paragraph (1), in the case of inpatient services which constitute skilled nursing facility services or intermediate care facility services, is a rate equal to the lesser of the rate described in subparagraph (A) or the allowable costs in effect under the State plan for such type of inpatient services provided to patients of such unit.

"(3) Any day on which an individual receives inpatient services for which payment is made under this subsection shall, for purposes of this Act (other than this subsection), be deemed to be a day on which the individual received inpatient hospital services.

"(4) For the purpose of determining the occupancy rate with respect to hospitals under paragraph (2)—

"(A) public hospitals under common ownership may elect (with the approval of the Secretary) to be treated as a single hospital, and

"(B) beginning two years after the date this subsection is first applied with respect to a hospital, the Secretary, to the extent feasible, shall not treat as an inpatient an individual with respect to whom payment is made to the hospital only because of this subsection or section 1861(v)(1)(G).".

(c) The amendments made by this section shall become effective on the date on which final regulations, promulgated by the Secretary to implement such amendments, are first issued; and those regulations shall be issued not later than the first day of the sixth month following the month in which this Act is enacted.

CONTINUED USE OF DEMONSTRATION PROJECT REIMBURSEMENT SYSTEMS

SEC. 903. (a) Section 1814(b) of the Social Security Act is amended—

(1) by inserting "except as provided in paragraph (3)," in paragraph (1) before "the lesser",

(2) by striking out "or" at the end of paragraph (1),

(3) by striking out the period at the end of paragraph (2) and inserting in lieu thereof "; or", and

(4) by adding at the end thereof the following new paragraph:

"(3) if some or all of the hospitals in a State have been reimbursed for services (for which payment may be made under this part) pursuant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972, if the rate of increase in such hospitals in their costs per hospital inpatient admission of individuals entitled to benefits under this part over the duration of such project was equal to or less than such rate of increase for admissions of such individuals with respect to all hospitals in the United States during such period, and if either the State has legislative authority to operate such system and the State elects to have reimbursement to such hospitals made in accordance with this paragraph or the system is operated through a voluntary agreement of hospitals and such hospitals elect to have reimbursement to those hospitals made in accordance with this paragraph, then the Secretary may provide for continuation of reimbursement to such hospitals under such system until the Secretary determines that—

"(A) a third-party payor reimburses such a hospital on a basis other than under such system, or

"(B) the rate of increase for the previous three-year period in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part is greater than such rate of increase for admissions of such individuals with respect to all hospitals in the United States for such period.

In the case of any State which has had such a demonstration project reimbursement system in continuous operation since July 1, 1977, the Secretary shall provide under paragraph (3) for continuation of reimbursement to hospitals in the State under such system until the Secretary determines that either of the conditions described in subparagraph (A) or (B) of such paragraph has occurred.".

(b) Section 1902(a)(13)(D)(i) of such Act, as amended by section 902(b)(1) of this title, is amended by inserting after "title XVIII" the following: ", except that in the case of hospitals reimbursed for services under part A of title XVIIII in accordance with section 1814(b)(3), the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section".

(c) Notwithstanding any other provision of law, the Secretary of Health and Human Services (hereinafter in this title referred to as the "Secretary") may not provide for more than a total of six Statewide medicare hospital reimbursement demonstration projects under the authority of section 402 of the Social Security Amendments of 1967 or of section 222 of the Social Security Amendments of 1972, including any such projects provided for before the date of the enactment of this Act.

HOSPITAL PROVIDERS OF LONG-TERM CARE SERVICES ("SWING-BEDS")

SEC. 904. (a)(1) Title XVIII of the Social Security Act is amended by adding after section 1882 the following new section:

"HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

"SEC. 1883. (a)(1) Any hospital (other than a hospital which has in effect a waiver under subparagraph (A) of the last sentence of section 1861(e)) which has an agreement under section 1866 may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

"(2)(A) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this section shall be based upon the reasonable cost of the services as determined under subparagraph (B).

"(B)(i) The reasonable cost of the services consists of the reasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services (determined under clause (iii)).

"(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this section is equal to the product of—

"(I) the number of patient-days during the year for which the services were furnished, and

"(II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the previous calendar year under the State plan (of the State in which the hospital is located) under title XIX to skilled nursing facilities located in the State and which meet the requirements specified in section 1902(a)(28), or, in the case of a hospital located in a State which does not have such a State plan, the average rate per patient-day paid for routine services during the previous calendar year under this title to skilled nursing facilities in such State.

"(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

"(b) The Secretary may not enter into an agreement under this section with any hospital unless—

"(1) except as provided under subsection (g), the hospital is located in a rural area and has less than 50 beds, and

"(2) the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 1521 of the Public Health Service Act) for the State in which the hospital is located.

"(c) An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866 and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section

1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866, or during which there is in effect for the hospital a waiver under subparagraph (A) of the last sentence of section 1861(e). A hospital with respect to which an agreement under this section has been terminated shall not be eligible to enter into a new agreement until a two-year period has elapsed from the termination date.

"(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

"(e) During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement due for routine services from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine title XVIII reimbursement for routine hospital services.

"(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

"(g) The Secretary may enter into an agreement under this section on a demonstration basis with any hospital which does not meet the requirement of subsection (b)(1), if the hospital otherwise meets the requirements of this section.".

(b) Title XIX of such Act is amended by adding after section 1912 the following new section:

"HOSPITAL PROVIDERS OF SKILLED NURSING AND INTERMEDIATE CARE SERVICES

"SEC. 1913. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under a State plan approved under this title for skilled nursing facility serv-

ices and intermediate care facility services furnished by a hospital which has in effect an agreement under section 1883.

"(b)(1) Payment to any such hospital, for any skilled nursing or intermediate care facility services furnished pursuant to subsection (a), shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under the State plan to skilled nursing and intermediate care facilities, respectively, located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

"(2) With respect to any period for which a hospital has an agreement under section 1883, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services due from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine reimbursement for routine hosptial services under the State plan.".

(c) Within three years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Congress a report evaluating the programs established by the amendments made by this section and shall include in such report an analysis of—

(1) the extent and effect of the agreements under such programs on availability and effective and economical provision of long-term care services,

(2) whether such programs should be continued,

(3) the results of any demonstration projects conducted under such programs, and

(4) whether eligibility to participate in such programs should be extended to other hospitals, regardless of bed size or geographic location, where there is a shortage of long-term care beds.

(d) The amendments made by this section shall become effective on the date on which final regulations, promulgated by the Secretary to implement such amendments, are first issued; and those regulations shall be issued not later than the first day of the sixth month following the month in which this Act is enacted.

WITHHOLDING OF FEDERAL SHARE OF PAYMENTS TO MEDICAID PROVIDERS TO RECOVER MEDICARE OVERPAYMENTS

SEC. 905. (a) Subparagraphs (D)(i) and (E) of section 1902(a)(13) of the Social Security Act are each amended by inserting "(except where the State agency is subject to an order under section 1914)" after "payment".

(b) Section 1903(a)(1) of such Act is amended by striking out "subject to subsections (g) and (h)" and inserting in lieu thereof "subject to subsections (g), (h), and (j)".

(c)(1) Section 1903(j) of such Act is amended to read a follows:

"(j) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1914.".

(2) Section 1903(n) of such Act is amended by striking out "or is subject to a suspension of payment order issued under subsection (j)".

(d) Title XIX of such Act is amended by adding after section 1913 (added by section 904(b) of this title) the following new section:

"WITHHOLDING OF FEDERAL SHARE OF PAYMENTS FOR CERTAIN MEDICARE PROVIDERS

"SEC. 1914. (a) The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for medical assistance for care or services furnished in any quarter by—

"(1) an institution (A) which has or previously had in effect an agreement with the Secretary under section 1866; and (B)(i) from which the Secretary has been unable to recover overpayments made under title XVIII, or (ii) from which the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII; and

"(2) any person (A) who (i) has previously accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii), and (ii) during the annual period immediately preceding such quarter submitted no claims for payment under title XVIII, or submitted claims for payment under title XVIII which aggregated less than the amount of overpayments made to him, and (B)(i) from whom the Secretary has been unable to recover overpayments received in violation of the terms of such assignment, or (ii) from whom the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such person under title XVIII.

"(b) The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this title for any quarter by an amount equal to the lesser of the Federal matching share of payments to any institution or person specified in subsection (a), or the total overpayments to such institution or person under title XVIII, and may require the State to reduce its payment to such institution or person by such amount.

"(c) The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to an institution or person, pursuant to subsection (b) until after he has provided adequate notice (which shall be not less than 60 days) to the State agency and the institution or person.

"(d) The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall (1) determine the amount of the Federal payment to which the institution or person would otherwise be entitled under this section which shall be treated as a setoff against overpayments under title XVIII, and (2) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under title XVIII and to which the institution or person would otherwise be entitled under this title.

"(e) The Secretary shall restore to the trust funds established under sections 1817 and 1841, as appropriate, amounts recovered under this section as setoffs against overpayments under title XVIII.

"(f) Notwithstanding any other provision of this title, an institution or person shall not be entitled to recover from any State any amount in payment for medical care and services under this title which is withheld by the State agency pursuant to an order by the Secretary under subsection (b).".

Subpart II—Other Administrative Provisions

QUALITY ASSURANCE PROGRAMS FOR CLINICAL LABORATORIES

SEC. 911. Section 1123(a) of the Social Security Act is amended by striking out "1977" and inserting in lieu thereof "1981".

REQUIREMENTS CONCERNING REPORTING OF FINANCIAL INTEREST

SEC. 912. (a) Section 1124(a)(3)(A)(ii) of the Social Security Act is amended to read as follows:

"(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds $25,000 or 5 per centum of the total property and assets of the entity; or".

(b) Section 1902(a)(35) of such Act is amended to read as follows:

"(35) provide that any disclosing entity (as defined in section 1124(a)(2)) receiving payments under such plan complies with the requirements of section 1124;".

EXCLUSION OF HEALTH CARE PROFESSIONALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

SEC. 913. (a) Part A of title XI of the Social Security Act is amended by inserting after section 1127 the following new section:

"EXCLUSION OF CERTAIN INDIVIDUALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

"SEC. 1128. (a) Whenever the Secretary determines that a physician or other individual has been convicted (on or after October 25, 1977, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such individual's participation in the delivery of medical care or services under title XVIII, XIX, or XX, the Secretary—

"(1) shall bar from participation in the program under title XVIII, for such period as he may deem appropriate, each such individual otherwise eligible to participate in such program;

"(2)(A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX or title XX, of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) require each such agency to bar such individual from participation in such program for such period as he shall specify, which in the case of an individual specified in para-

graph (1) shall be the period established pursuant to paragraph (1);

"(B) may waive the requirement under subparagraph (A) to bar an individual from participation in a State plan program under title XIX or title XX, where he receives and approves a request for such a waiver with respect to that individual from the State agency administering or supervising the administration of such plan; and

"(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such individual of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.

"(b) A determination made by the Secretary under this section shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services furnished under title XVIII, such determination shall be effective in the manner provided in paragraphs (3) and (4) of section 1866(b) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

"(c) Any person who is the subject of an adverse determination made by the Secretary under subsection (a) shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).".

(b) Section 1862(e) of such Act is amended to read as follows:

"(e) No payment may be made under this title with respect to any item or service furnished by a physician or other individual during the period when he is barred pursuant to section 1128 from participation in the program under this title.".

(c) Section 1902(a)(39) of such Act is amended to read as follows:

"(39) provide that the State agency shall bar any specified individual from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1128, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual during such period;".

(d) Section 1902(g) of such Act is repealed.

(e) Section 2003(d)(1) of such Act is amended—

(1) by striking out "and" at the end of subparagraph (I),

(2) by striking out the period at the end of subparagraph (J) and inserting in lieu thereof "; and", and

(3) by inserting after subparagraph (J) the following new subparagraph:

"(K) provides that the State will bar any specified individual from participation in the program for the period specified by the Secretary when required by him to do so pursuant to section 1128, and provides that no payment may be made under the program with respect to any item or service furnished by such individual during such period.".

COORDINATED AUDITS UNDER THE SOCIAL SECURITY ACT

SEC. 914. (a) Title XI of the Social Security Act is amended by inserting after section 1128 (added by section 913(a) of this title) the following new section:

"COORDINATED AUDITS

SEC. 1129. (a) If an entity provides services reimbursable on a cost-related basis under title V or XIX, as well as services reimbursable on such a basis under title XVIII, the Secretary shall require, as a condition for payment to any State under title V or XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of title XVIII. The Secretary shall specify by regulation such methods as he finds feasible and equitable for the apportionment of the cost of coordinated audits between the program established under title V or XIX and the program established under title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to title V or XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be in excess of the amount that would have been apportioned to the State under the title (for the expenses of the Sate incurred in the common audity) if it had participated in the common audit.

"(b)(1) In the case of entities which have audits coordinated under subsection (a), the Secretary shall establish one or more projects to demonstrate the feasibility of creating a single coordinated appeal hearing to adjudicate those administrative cost items which are determined under such a coordinated audit and which such entities dispute and appeal.

"(2) In the case of a demonstration project under this subsection, the Secretary may waive such requirements of title V, XVIII, or XIX as would prevent carrying out the project or would require duplicative activity or otherwise create unnecessary administrative burdens in carrying out the project.

"(3) The Secretary shall report to Congress not later than December 31, 1982, with respect to demonstration projects conducted under this subsection, including the reaction of the entities involved and estimates of any savings effected through reduction of duplication of appeal hearings, and shall include in such report recommendations for such legislation as the Secretary deems appropriate to insure the maximum feasible coordination of such appeal hearings.

"(4) The Secretary shall also provide for the review of the feasibility of establishing a single coordinated process for the collection of overpayments established in a coordinated audit under subsection (a). The Secretary shall report to Congress not later than December 31, 1981, on such review and on such recommendations for changes in legislation as the Secretary deems appropriate.".

(b)(1) Section 1902(a) of such Act is amended—

(A) by striking out "and" at the end of paragraph (40);

(B) by striking out the period at the end of paragraph (41) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (41) the following new paragraph:

"(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1129(a).".

(2)(A) The amendments made by paragraph (1) shall (except as provided under subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after the first day of the first calendar quarter beginning more than 30 days after the date of the enactment of this Act.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(c)(1) Section 505(a) of such Act is amended—

(A) by striking out "and" at the end of paragraph (14);

(B) by striking out the period at the end of paragraph (15) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (15) the following new paragraph:

"(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit

as is determined under methods specified by the Secretary under section 1129(a).".

(2) The amendments made by paragraph (1) shall apply to services provided, under a State plan approved under title V of the Social Security Act, on and after the first day of the first calendar quarter beginning more than 30 days after the date of the enactment of this Act.

(d) The Secretary shall report to the Congress, not later than December 31, 1981, on actions the Secretary has taken (1) to coordinate the conduct of institutional audits and inspections which are required under the programs funded under title V, XVIII, or XIX of the Social Security Act, and (2) to coordinate such audits and inspections with those conducted by other cost payers, and he shall include in such report recommendations for such legislation as he deems appropriate to assure the maximum feasible coordination of such institutional audits and inspections.

LIFE SAFETY CODE REQUIREMENTS

SEC. 915. (a) Section 1861(j)(13) of the Social Security Act is amended by striking out "the Life Safety Code of the National Fire Protection Association (23d edition, 1973)" and inserting in lieu thereof "such edition (as specified by the Secretary in regulations) of the Life Safety Code of the National Fire Protection Association".

(b) Any institution (or part of an institution) which complied with the requirements of section 1861(j)(13) of the Social Security Act on the day before the date of the enactment of this Act shall, so long as such compliance is maintained (either by meeting the applicable provisions of the Life Safety Code (21st edition, 1967, or 23d edition, 1973), with or without waivers of specific provisions, or by meeting the applicable provisions of a fire and safety code imposed by State law as provided for in such section 1861(j)(13), be considered (for purposes of titles XVIII or XIX of such Act) to be in compliance with the requirements of such section 1861(j)(13), as it is amended by subsection (a) of this section.

ALTERNATIVE TO DECERTIFICATION OF LONG-TERM CARE FACILITIES OUT OF COMPLIANCE WITH CONDITIONS OF PARTICIPATION; LOOK BEHIND AUTHORITY

SEC. 916. (a) Section 1866 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which has been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies—

"(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

"(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act to deny payment under such title XIX) with respect to any individual admitted to such facility after a date specified by him.

"(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

"(3) The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of section 1861(j) on the date specified in such clause, the Secretary shall terminate such facility's agreement or provide for termination of such facility's certification, notwithstanding the provisions of paragraph (2) of subsection (b), effective with the first day of the first month following the month specified in such clause.".

(b)(1)(A) Section 1902 of such Act is amended by adding after subsection (h) (added by section 902(b)(2) of this title) the following new subsection:

"(i)(1) In addition to any other authority under State law, where a State determines that a skilled nursing facility or intermediate care facility which is certified for participation under its plan no longer substantially meets the provisions of section 1861(j) or section 1905(c), respectively, and further determines that the facility's deficiencies—

> *"(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or*
>
> *"(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide*

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

"(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j) or section 1905(c) (as the case may be), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

"(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be

provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j) or section 1905(c) (as the case may be), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.".

(B) Such section is further amended by inserting before the semicolon at the end of subsection (a)(33)(B) the following: ", except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation".

(2) Section 1910 of such Act is amended by adding at the end thereof the following new subsection:

"(c)(1) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

"(2) Any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.".

CRIMINAL STANDARDS FOR CERTAIN MEDICARE- AND MEDICAID-RELATED CRIMES

SEC. 917. Paragraphs (1) and (2) of section 1877(b) of the Social Security Act and of section 1909(b) of such Act are each amended by inserting "knowingly and willfully" after "Whoever".

REIMBURSEMENT OF CLINICAL LABORATORIES

SEC. 918. (a)(1) Section 1842 of the Social Security Act is amended by inserting at the end the following new subsection:

"(h) If a physician's bill or request for payment for a physician's services includes a charge to a patient for a laboratory test for which payment may be made under this part, the amount payable with respect to the test shall be determined as follows:

"(1) If the bill or request for payment indicates that the physician who submitted the bill or for whose services the request for payment was made personally performed or supervised the performance of the test or that another physician with whom the physician shares his practice personally performed or supervised the test, the payment shall be the reasonable charge for the test (less the applicable deductible and coinsurance amounts).

"(2) If the bill or request for payment indicates that the test was performed by a laboratory, identifies the laboratory, and indicates the amount the laboratory charged the physician who submitted the bill or for whose services the request for payment was made, payment for the test shall be the lower of—

"(A) the laboratory's reasonable charge to individuals enrolled under this part for the test, or

"(B) the amount the laboratory charged the physician for the test,

plus a nominal fee (where the physician bills for such a service) to cover the physician's costs in collecting and handling the sample on which the test was performed (less the applicable deductible and coinsurance amounts).

"(3) If the bill or request for payment (A) does not indicate who performed the test, or (B) indicates that the test was performed by a laboratory but does not identify the laboratory or include the amount charged by the laboratory, payment shall be the lowest charged at which the carrier estimates the test could have been secured by a physician from a laboratory serving the locality (less the applicable deductible and coinsurance amounts).".

(2) The amendment made by paragraph (1) shall apply to bills submitted and requests for payment made on or after such date (not later than April 1, 1981) as the Secretary of Health and Human Services prescribes by a notice published in the Federal Register.

(3) Not later than 24 months after the effective date specified in paragraph (2), the Secretary shall report to the Congress—

(A) the proportion of bills and requests for payment submitted (during the 18-month period beginning on such effective date) under title XVIII of the Social Security Act for laboratory tests which did not identify who performed the tests,

(B) the proportion of bills and requests for payment submitted during such period for laboratory tests with respect to which the amount paid under such title was less than the amount that would otherwise have been payable in the absence of section 1842(h) of such Act,

(C) with respect to requests for payment described in subparagraph (B) which were submitted by patients, the average additional cost per laboratory test to patients resulting from reductions in payment that would otherwise have been made for such tests in the absence of such section 1842(h), and

(D) with respect to bills described in subparagraph (B) which were submitted by physicians, the average reduction in payment per laboratory test to physicians resulting from the application of such section 1842(h).

(4) Section 1833(a)(1)(D) of the Social Security Act is amended by striking out "subsection (g)" and inserting in lieu thereof "subsection (h)".

(b)(1) Section 1902(a) of the Social Security Act (as amended by section 914(b)(1) of this Act) is further amended—

(A) by striking out "and" at the end of paragraph (41);

(B) by striking out the period at the end of paragraph (42) and inserting in lieu thereof "; and"; and

(C) by adding after paragraph (42) the following new paragraph:

"(43) if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician (or any other physician with whom he shares his practice) did not personally perform or supervise, include provision to insure that payment under the State plan for such laboratory services not exceed the payment authorized for such services by section 1842(h).".

(2)(A) The amendments made by paragraph (1) shall (except as otherwise provided in subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after the first day of the first calendar quarter that begins more than six months after the date of the enactment of this Act.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

STUDY OF NEED FOR DUAL PARTICIPATION OF SKILLED NURSING FACILITIES

SEC. 919. (a)(1) The Secretary of Health and Human Services shall conduct a study of the availability and need for skilled nursing facility services covered under part A of title XVIII of the Social Secu-

rity Act and under State plans approved under title XIX of such Act.

(2) Such study shall include—

(A) an investigation of the desirability and feasibility of imposing a requirement that skilled nursing facilities (i) which furnish services to patients covered under State plans approved under title XIX of the Social Security Act also furnish such services to patients covered under part A of title XVIII of such Act, and (ii) which furnish services to patients covered under such title XVIII also furnish such services to patients covered under such State plans,

(B) an evaluation of the impact of existing laws and regulations on skilled nursing facilities and individuals covered under such State plans and under part A of such title XVIII, and an evaluation of the extent to which existing laws and regulations encourage skilled nursing facilities to accept only title XVIII beneficiaries or title XIX recipients, and

(C) an investigation of possible changes in regulations and legislation which would result in encouraging a greater availability of skilled nursing facility services.

(3) In developing such study, the Secretary shall consult with professional organizations, health experts, private insurers, nursing home providers, and consumers of skilled nursing facility services.

(b) Within one year after the date of the enactment of this Act, the Secretary shall complete such study and shall submit to the Congress a full and complete report thereon, together with recommendations with respect to the matters covered by such study (including any recommendations for administrative or legislative changes).

Subpart III—Provisions Relating to Professional Standards Review Organizations (PSRO's)

EXPANDED MEMBERSHIP OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 921. Section 1152(b)(1)(A) of the Social Security Act is amended—

(1) by inserting "and, if the organization so elects, of other health care practitioners engaged in the practice of their professions in such area who hold independent hospital admitting privileges," after the comma at the end of clause (ii); and

(2) by inserting "(except as otherwise provided under section 1155(c))" after "does not" in clause (vi).

REGISTERED NURSE AND DENTIST MEMBERSHIP ON STATEWIDE COUNCIL ADVISORY GROUP

SEC. 922. (a) Section 1162(e)(1) of the Social Security Act is amended by inserting "(including at least one registered professional nurse and at least one doctor of dental surgery or of dental medicine)" after "representatives."

(b) The amendment made by this section shall become effective 180 days after the date of the enactment of this Act.

NONPHYSICIAN MEMBERSHIP ON NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

SEC. 923. (a) Section 1163(a)(1) of the Social Security Act is amended by inserting "one doctor of dental surgery or of dental medicine, one registered professional nurse, and one other health practitioner (other than a physician as defined in section 1861(r)(1)), " after "physicians,".

(b) Section 1163(a)(2) of such Act is amended by striking out "four members" and inserting in lieu thereof "five members".

(c) Section 1163(a)(3) of such Act is amended by inserting "physician" before "members".

(d) Section 1163(b) of such Act is amended by striking out "Members" and inserting in lieu thereof "Physician members".

(e) Section 1173 of such Act is amended by striking out "(except sections 1155(c) and 1163)" and inserting in lieu thereof "(except section 1155(c))".

(f) The amendments made by this section shall become effective 180 days after the date of the enactment of this Act.

REQUIRED ACTIVITIES OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 924. (a)(1) Subsection (b) of section 1154 of the Social Security Act is amended—

(A) by striking out "in addition to review of health care services provided by or in institutions, only such of the duties and functions required under this part of Professional Standards Review Organization as he determines such organization to be capable of performing" in the first sentence and inserting in lieu thereof "in addition to review of health care services (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals and to review of alcohol detoxification facility services, only such of the duties and functions as he requires the organization to perform under subsection (f)(2) or subsection (f)(4) and which the organization is capable of performing"; and

(B) by striking out "only if the Secretary finds that it is substantially carrying out in a satisfactory manner, the activities and functions required of Professional Standards Review Organizations under this part with respect to the review of health care services provided by or in institutions (including ancillary services) and, in addition, review of such other health care services as the Secretary may require" in the second sentence and inserting in lieu thereof "only if the Secretary finds that it is substantially carrying out in a satisfactory manner the activities and functions required of that Professional Standards Review Organization under this part".

(2) Subsection (c) of such section is amended by inserting "of that organization" after "required under this part".

(3) Such section if further amended by adding at the end the following new subsection:

"(f)(1) The Secretary shall establish a program (hereinafter in this subsection referred to as the 'program') for the evaluation of the

cost-effectiveness of review of particular health care services by Professional Standards Review Organizations.

"(2) In order to demonstrate the cost-effectiveness of requiring review of particular health care services before such review is generally required, the program shall be designed in a manner so that the Secretary will require particular Professional Standards Review Organizations, chosen by a statistically valid method that will permit a valid evaluation of the cost-effectiveness of such review, to review particular health care services.

"(3) The program shall provide for the evaluation of cost-effectiveness of the review of particular health care services under the program, particularly in comparison with areas in which such review was not required or performed.

"(4) Based upon such evaluation, or upon an evaluation of comparable statistical validity, and a finding that review of particular health care services is cost-effective or yields other significant benefits, the Secretary shall such particular health care services which Professional Standards Review Organizations (either generally or under such conditions and circumstances as the Secretary may specify) have the duty and function of reviewing under this part.

"(5) For purposes of this subsection, the term 'particular health care services' does not include health care service (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals or alcohol detoxification facility services.".

(b) Section 1155(a) of such Act is amended—

(1) by striking out "at the earliest date practicable" in paragraph (1) and inserting in lieu thereof "to the extent and at the time specified by the Secretary under section 1154(f)";

(2) by inserting ", consistent with section 1154(f)," in paragraph (7)(A) after "only"; and

(3) by inserting "(consistent with section 1154(f))" in paragraph (7)(B) after "to the extent".

(c) Subsection (g) of section 1155 of such Act is repealed.

(d) Section 1155 of such Act is amended by adding at the end thereof the following new subsection:

"(h) If the Secretary has designated an organization (other than under section 1154) as a Professional Standards Review Organization, but that organization has not assumed responsibility for the review of particular activities in its area included in subsection (a)(1), the Secretary may designate another qualified Professional Standards Review Organization (in reasonable proximity to the providers and practitioners whose services are to be reviewed) to assume the responsibility for the review of some or all of those particular activities.".

EFFICIENCY IN DELEGATED REVIEW

SEC. 925. Section 1155(e) of the Social Security Act is amended by striking out "effectively and in timely fashion" and inserting in lieu thereof "effectively, efficiently, and in timely fashion".

REVIEW OF ROUTINE HOSPITAL ADMISSION SERVICES AND PREOPERATIVE HOSPITAL STAYS BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 926. Section 1155(a)(2) of the Social Security Act is amended to read as follows:

"(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

"(A) any elective admission to a hospital or other health care facility (including admissions occurring on weekends), and

"(B) any routine diagnostic services furnished in connection with such an admission,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in subparagraphs (A) and (C) of paragraph (1). Each such Organization may be directed by the Secretary to excercise such authority where the Secretary finds (consistent with section 1154(f)) that such determinations can be made on a timely basis by the Organization and appropriate procedures will be applied to assure prompt notification of such determinations to providers, physicians, practitioners, and persons on whose behalf payment may be made under this Act for services and items.".

CONSULTATION BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS WITH HEALTH CARE PRACTITIONERS

SEC. 927. (a) Section 1155(a) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(8) Each Professional Standards Review Organization shall consult (with such frequency and in such manner as may be prescribed by the Secretary) with representatives of health care practitioners (other than physicians described in section 1861(r)(1)) and of institutional and noninstitutional providers of health care services, in relation to the Professional Standards Review Organization's responsibility for the review under paragraph (1) of the professional activities of such practitioners and providers.".

(b) Section 1162(e) of such Act is amended by striking out the first parenthetical material in paragraph (1) and the parenthetical material in paragraph (2).

(c) The amendments made by this section shall become effective 180 days after the date of the enactment of this Act.

RESPONSE OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS TO FREEDOM OF INFORMATION ACT REQUESTS

SEC. 928. No Professional Standards Review Organization designated (conditionally or otherwise) under part B of title XI of the Social Security Act shall be required to make available any records pursuant to a request made under section 552 of title 5, United States Code, until the later of (1) one year after the date of entry of a final court order requiring that such records be made available, or (2) the last date of the Congress during which the court order was entered.

STUDY OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS NORMS, STANDARDS, AND CRITERIA

SEC. 929. The Secretary of Health and Human Services shall, in consultation with the National Professional Standards Review Council, conduct a nationwide study of the differences in medical criteria and length-of-stay norms utilized by Professional Standards Review Organizations in the various regions of the country. The study shall include an assessment of the rationale that contributes to these regional differences. The Secretary shall report the findings and conclusions made with respect to the study to the Congress within one year after the date of the enactment of this Act.

PART B—PROVISIONS RELATING TO MEDICARE

Subpart I—Changes in Services or Benefits

HOME HEALTH SERVICES

SEC. 930. (a) Section 1811 of the Social Security Act is amended by striking out "and related post-hospital services" and inserting in lieu thereof ", related post-hospital, and home health services".

(b) Section 1812(a)(3) of such Act is amended to read as follows:

"(3) home health services.".

(c) Section 1812(d) of such Act is repealed.

(d) Section 1812(e) of such Act is amended—

(1) by striking out "(b), (c), and (d)" and inserting in lieu thereof "(b) and (c)"; and

(2) by striking out "post-hospital extended care services, and post-hospital home health services" and inserting in lieu therof "and post-hospital extended care services".

(e) Sections 1814(a) and 1835(a) of such Act are amended by adding the following new sentence at the end of each such section: "With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan.".

(f) Section 1814(a)(2)(D) of such Act is amended—

(1) by striking out "post-hospital home health services" and inserting in lieu thereof "home health services";

(2) by inserting ", occupational," after "or physical"; and

(3) by striking out ", for any of the conditions" and all that follows through "extended care services".

(g) Section 1832(a)(2)(A) of such Act is amended by striking out "for up to 100 visits during a calendar year".

(h) Section 1833(b) of such Act is amended—

(1) by striking out "and" at the end of clause (1) in the first sentence; and

(2) by inserting before the period at the end of the first sentence the following: ", (3) such deductible shall not apply with respect to home health services".

(i) Section 1834 of such Act is repealed.

(j) Section 1835(a)(2)(A) of such Act is amended by inserting ", occupational," after "or physical".

(k) Section 1861(e) of such Act is amended—

(1) by striking out "subsections (i) and (n)" in the material preceding paragraph (1) and inserting in lieu thereof "subsection (i)", and

(2) by striking out "subsections (i) and (n)" in the third sentence and inserting in lieu thereof "subsection (i)".

(l) Section 1861(m)(4) of such Act is amended by inserting the following before the semicolon: "who has successfully completed a training program approved by the Secretary".

(m) Section 1861(n) of such Act is repealed.

(n) Section 1861(o) of such Act is amended—

(1) by striking out "and" at the end of paragraph (5), by inserting "and" at the end of paragraph (6), and by adding the following new paragraph after paragraph (6):

"(7) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program;"; and

(2) by striking out "except that" the first place it appears in the material following paragraph (6) and all that follows through "regulations; and".

(o) Section 1816(e) of such Act is amended—

(1) by inserting "(subject to the provisions of paragraph (4))" after "the Secretary may" in paragraph (2); and

(2) by adding the following new paragraph at the end thereof:

"(4) Notwithstanding subsections (a) and (d) and paragraphs (1), (2), and (3) of this subsection, the Secretary shall designate regional agencies or organizations which have entered into an agreement with him under this section to perform functions under such agreement with respect to home health agencies (as defined in section 1861(o)) in the region, except that in assigning such agencies to such designated regional agencies or organizations the Secretary shall assign a home health agency which is a subdivision of a hospital (and such agency and hospital are affiliated or under common control) only if, after applying such criteria relating to administrative efficiency and effectiveness as he shall promulgate, he determines that such assignment would result in the more effective and efficient administration of this title.".

(p) Section 1861(v)(1) of such Act is amended by adding after subparagraph (G) (as added by section 902(a)(1) of this title) the following new subparagraph:

"(H) In determining such reasonable cost with respect to home health agencies, the Secretary may not include—

"(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of the financial security requirement described in subsection (o)(7);

"(ii) in the case of home health agencies to which the financial security requirement described in subsection (o)(7) applies,

any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this title to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

"(iii) in the case of contracts entered into by a home health agency after the date of the enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract (I) which is entered into for a period exceeding five years, or (II) which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency; and

"(iv) in the case of contracts entered into by a home health agency before the date of the enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract, which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency, to the extent that such cost exceeds the reasonable value of the services furnished on behalf of such agency.".

(q) Section 226(c)(1) of such Act is amended—

(1) by striking out "and post-hospital home health services" and inserting in lieu thereof "and home health services"; and

(2) by striking out "or post-hospital home health services" in clause (B).

(r) Section 7(d)(1) of the Railroad Retirement Act of 1974 is amended by striking out "posthospital home health services" and inserting in lieu thereof "home health services".

(s)(1) The amendments made by this section shall become effective with respect to services furnished on or after July 1, 1981, except that the amendments made by subsections (n)(1) and (o) shall become effective on the date of the enactment of this Act.

(2) The Secretary of Health and Human Services shall take administrative action to assure that improvements, in accordance with the amendment made by subsection (n)(1), will be made not later than June 30, 1981.

ALCOHOL DETOXIFICATION FACILITY SERVICES

SEC. 931. (a) Section 1812 of the Social Security Act is amended by striking out "and" at the end of paragraph (2), by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; and", and by adding after paragraph (3) the following new paragraph:

"(4) alcohol detoxification facility services.".

(b) Section 1814(a)(2) of such Act is amended by striking out "or" at the end of subparagraph (D), by inserting "or" at the end of subparagraph (E), and by adding after subparagraph (E) the following new subparagraph:

"(F) in the case of alcohol detoxification facility services, such services are required on an inpatient basis (based upon an examination by such certifying physician made prior to initiation of alcohol detoxification);".

(c) Section 1861(u) of such Act is amended by inserting "detoxification facility," after "home health agency,".

(d) Section 1861 of such Act is further amended by adding after subsection (aa) the following new subsection:

"Alcohol Detoxification Facility Services

"(bb)(1) The term 'alcohol detoxification facility services' means services provided by a detoxification facility in order to reduce or eliminate the amount of alcohol in the body, but only to the extent that such services would be covered under subsection (b) if furnished as inpatient services by a hospital, or are physicians' services covered under subsection (s).

"(2) The term 'detoxification facility' means a public or voluntary community-based nonprofit facility, other than a hospital, which—

"(A) is engaged in furnishing to inpatients the services described in paragraph (1);

"(B) is accredited by the Joint Commission on the Accreditation of Hospitals as meeting the Accreditation Program for Psychiatric Facilities standards (1979 edition), or is found by the Secretary to meet such standards;

"(C) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring services not available at the facility; and

"(D) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by the facility.".

(e) The amendments made by subsections (a) through (d) of this section shall become effective on April 1, 1981.

(f) The Secretary of Health and Human Services shall conduct a study and make recommendations, within 18 months after the date of the enactment of this Act, concerning the appropriateness of extending medicare coverage to drug detoxification, postdetoxification rehabilitation, and to outpatient detoxification and concerning incentives for the use of lower-cost detoxification facilities.

(g) Section 1155 of the Social Security Act is amended by adding after subsection (h) (added by section 924(d) of this title) the following new subsection:

"(i) Any Professional Standards Review Organization which has assumed responsibility under this section for review of inpatient hospital services in an area shall also assume responsibility in such area for review of detoxification facility services.".

(h) Section 1158 of such Act is amended—

(1) by striking out "section 1159 and subsection (d)" in subsection (a) and inserting in lieu thereof "subsections (d) and (e) of this section and in sections 1159, 1861(v)(1)(G), and 1902(h)", and

(2) by adding after subsection (d) the following new subsection:

"(c) Subsection (a) of this section shall not apply to a determination by a Professional Standards Review Organization under section 1155(a)(1)(C) that detoxification services provided or proposed to be provided in a hospital on an inpatient basis could be more economically provided in a detoxification facility.".

PREADMISSION DIAGNOSTIC TESTING

SEC. 932. (a)(1) Section 1833(a)(1) of the Social Security Act is amended—

(A) by striking out "and (E)" and inserting in lieu thereof "(E)", and

(B) by inserting the following after "section 1881," at the end of clause (E): "(F) with respect to expenses incurred for physicians' services (furnished by a physician who has an agreement in effect with the Secretary by which the physician agrees to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all physicians' services which are preadmission diagnostic services furnished by the physician to individuals enrolled under this part) which are preadmission diagnostic services for which payment may be made under this part and which are furnished (i) in the outpatient department of a hospital within seven days of such individual's admission to the same hospital as an inpatient or, to the extent practicable as determined by regulations prescribed by the Secretary, to another hospital, or (ii) to the extent practicable as determined by regulations prescribed by the Secretary, in a physician's office within seven days of such individual's admission to a hospital as an inpatient, the amounts paid shall be equal to the reasonable charges for such services,".

(2) For amendment to section 1833(a) of the Social Security Act, with respect to the amount of payment for hospital outpatient preadmission diagnostic services, see section 942 of this title.

(b) The Secretary of Health and Human Services shall transmit to the Congress, no later than one year after the date of the enactment of this Act, a report describing the policy which has been developed and is being or will be implemented with respect to the amendments made by subsection (a)(1) of this section and by section 942 of this title as they concern expenses incurred for preadmission diagnostic testing furnished to an individual at a hospital within seven days of an individual's admission to another hospital.

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES

SEC. 933. (a) Section 1832(a)(2) of the Social Security Act is amended by striking out "and" at the end of subparagraph (C), by striking out the period at the end of subparagraph (D) and inserting in lieu thereof a semicolon, and by adding the following new subparagraph at the end thereof:

"(E) comprehensive outpatient rehabilitation facility services; and".

(b) Section 1835(a)(2) of such Act is amended by striking out the period at the end of subparagraph (D) and inserting in lieu thereof a semicolon, and by inserting the following new subparagraph after subparagraph (D):

"(E) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; and".

(c) Section 1861(u) of such Act is amended by inserting "comprehensive outpatient rehabilitation facility," immediately after "skilled nursing facility,".

(d) Section 1861(z) of such Act is amended by striking out "extended care facility," and inserting in lieu thereof "skilled nursing facility, comprehensive outpatient rehabilitation facility,".

(e) Section 1861 of such Act is amended by adding after subsection (bb) (added by section 931(d) of this title) the following new subsection:

"Comprehensive Outpatient Rehabilitation Facility Services

"(cc)(1) The term 'comprehensive outpatient rehabilitation facility services' means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

"(A) physicians' services;

"(B) physical therapy, occupational therapy, speech pathology services, and respiratory therapy;

"(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

"(D) social and psychological services;

"(E) nursing care provided by or under the supervision of a registered professional nurse;

"(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self administered;

"(G) supplies, appliances, and equipment, including the purchase or rental of equipment; and

"(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an outpatient of a hospital.

"(2) The term 'comprehensive outpatient rehabilitation facility' means a facility which—

"(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons;

"(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians, as defined in section 1861(r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

"(C) maintains clinical records on all patients;

"(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

"(E) has a requirement that every patient must be under the care of a physician;

"(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standard establishment for such licensing;

"(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

"(H) has in effect an overall plan and budget that meets the requirements of subsection (z); and

"(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.".

(f) Section 1863 of such Act is amended by striking out "and (o)(6)" in the first sentence and inserting in lieu thereof "(o)(6), and (cc)(2)(I)".

(g) Section 1864(a) of such Act is amended—

(1) by inserting "or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc)(2)" after "section 1861(aa)(2)" in the first sentence; and

(2) by inserting "comprehensive outpatient rehabilitation facility," after "rural health clinic," each place it appears in the second and fifth sentences.

(h) The amendments made by this section shall become effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period which begins on or after July 1, 1981.

OUTPATIENT SURGERY

SEC. 934. (a) Section 1832(a)(2) of the Social Security Act is amended by adding after subparagraph (E) (added by section 933(a) of this title) the following new subparagraph:

"(F) facility services furnished in connnection with surgical procedures specified by the Secretary—

"(i) pursuant to section 1833(i)(1)(A) and performed in an ambulatory surgical center (which meets health, safety, and other standards specified by the Secretary in regulations) if the center has an agreement in effect with the Secretary by which the center agrees to accept the amount determined under section 1833(i)(2)(A) as full payment for such services and to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all such services furnished by the center to individuals enrolled under this part, or

"(ii) pursuant to section 1833(i)(1)(B) and performed by a physician, described in section 1861(r)(1), in his office, if the Secretary has determined that—

"(I) a Professional Standards Review Organization (designated, conditionally or otherwise, under part B of title XI of this Act) is willing, able, and has agreed to carry out a review (on a sample or other reasonable basis) of the physician's performing such procedures in the physician's office,

"(II) the particular physician involved has agreed to make available to such Organization such records as the Secretary determines to be necessary to carry out the review, and

"(III) the physician is authorized to perform the procedure in a hospital located in the area in which the office is located;

and if the physician agrees to accept the amount determined under section 1833(i)(2)(B) as full payment for such services and to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with such surgical procedure to individuals enrolled under this part.".

(b) Section 1833 of such Act is amended by adding at the end the following new subsection:

"(i)(1) The Secretary shall, in consultation with the National Professional Standards Review Council and appropriate medical organizations—

"(A) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center (meeting the standards specified under section 1832(a)(2)(F)(i)) or hospital outpatient department, and

'(B) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in a physician's office.

"(2)(A) The amount of payment to be made for facility services furnished in connection with a surgical procedure specified pursuant to paragraph (1)(A) and furnished to an individual in an ambulatory surgical center described in such paragraph shall be equal to a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

"(i) takes into account the costs incurred by such centers, or classes of centers generally in providing services furnished in connection with the performance of such procedure, and

"(ii) takes such costs into account in such a manner as will assure that the performance of the procedure in such a center will result in substantially less amounts paid under this title

than would have been paid if the procedure had been performed on an inpatient basis in a hospital.

Each amount so established shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

"(B) The amount of payment to be made under this part for facility services furnished, in connection with a surgical procedure specified pursuant to paragraph (1)(B), in a physician's office shall be equal to a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

"(i) takes into account additional costs, not usually included in the professional fee, incurred by physicians in securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and

"(ii) takes such items into account in such a manner which will assure that the performance of such procedure in the physician's office will result in substantially less amounts paid under this title than would have been paid if the services had been furnished on an inpatient basis in a hospital.

Each amount so established shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

"(3) In the case of services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with surgical procedures (specified pursuant to paragraph (1) of this subsection) in a physician's office, an ambulatory surgical center described in such paragraph, or a hospital outpatient department, payment for such services shall be determined in accordance with subsection (a)(1)(G) if the physician accepts an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for such services.

"(4)(A) The Secretary is authorized to provide by regulations that in the case of a surgical procedure, specified by the Secretary pursuant to paragraph (1)(A), performed in an ambulatory surgical center described in such paragraph, there shall be paid (in lieu of any amounts otherwise payable under this part) with respect to the facility services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to subparagraph (B), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

"(B) In implementing this paragraph, the Secretary shall establish with respect to each surgical procedure specified pursuant to paragraph (1)(A) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.".

(c)(1) Section 1863 of the Social Security Act is amended by inserting "or by ambulatory surgical centers under section 1832(a)(2)(F)(i)," after "section 1861,".

(2) Section 1864(a) of such Act is amended—

(A) by inserting before the period at the end of the first sentence the following: ", or whether an ambulatory surgical center meets the standards specified under section 1832(a)(2)(F)(i)"; and

(B) by inserting "ambulatory surgical center," in the fifth sentence after "health care facility," each place it appears.

(d)(1) Section 1833(a)(1) of such Act, as amended by section 932(a)(1) of this title, is further amended by inserting after the comma at the end of clause (F) the following new clause: "and (G) with respect to expenses incurred for services described in subsection (i)(3) under the conditions specified in such subsection, the amounts paid shall be the reasonable charge for such services,".

(2) For an additional amendment to section 1833(a) of the Social Security Act with respect to the amount of payment for outpatient surgical procedures, see section 942 of this title.

(3) The first sentence of section 1833(b) of such Act, as amended by section 930(h) of this title, is further amended by adding before the period at the end the following: ", and (4) such total amount shall not include expenses incurred for services the amout of payment for which is determined under subsection (a)(1)(G) or under subsection (i)(2) or (i)(4)".

OUTPATIENT PHYSICAL THERAPY SERVICES

SEC. 935. (a) Section 1833(g) of the Social Security Act is amended by striking out "$100" and inserting in lieu thereof "$500".

(b) The amendment made by subsection (a) shall apply to expenses incurred in calendar years beginning with calendar year 1982.

DENTISTS' SERVICES

SEC. 936. (a) Clause (2) of the first sentence of section 1861(r) of the Social Security Act is amended to read as follows: "(2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions,".

(b) Section 1814(a)(2)(E) of such Act is amended to read as follows:

"(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, require hospitalization in connection with the provision of such services; or".

(c) Section 1862(a)(12) of such Act is amended by inserting "or because of the severity of the dental procedure," after "clinical status".

(d) The amendments made by this section shall apply with respect to services provided on or after July 1, 1981.

OPTOMETRISTS' SERVICES

SEC. 937. (a) Clause (4) of the first sentence of section 1861(r) of the Social Security Act is amended by striking out "but only with respect to establishing the necessity for prosthetic lenses," and inserting in lieu thereof "but only with respect to services related to the condition of aphakia,".

(b) The Secretary of Health and Human Services shall submit to Congress by January 1, 1982, legislative recommendations with respect to reimbursement under title XVIII of the Social Security Act for services furnished by optometrists in connection with cataracts and such other services which they are legally authorized to perform.

(c) The amendment made by subsection (a) shall apply to services furnished on on after July 1, 1981.

ANTIGENS

SEC. 938. Section 1861(s)(2) of the Social Security Act is amended by striking out "and" at the end of subparagraph (E), by adding "and" after the semicolon at the end of subparagraph (F), and by inserting the following new subparagrpah after subparagraph (F):

> *"(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;".*

(b) The amendments made by subsection (a) shall apply to services furnished on or after January 1, 1981.

TREATMENT OF PLANTAR WARTS

SEC. 939. (a) Section 1862(a)(13)(C) of the Social Security Act is amended by striking out ", warts,".

(b) The amendment made by subsection (a) shall apply with respect to services furnished on or after July 1, 1981.

Subpart II—Administrative Changes and Miscellaneous Provisions

PRESUMED COVERAGE PROVISIONS

SEC. 941. (a) Section 1814 of the Social Security Act is amended by striking out subsections (h) and (i) and by redesignating subsection (j) as subsection (h).

(b) Section 1814(c) of such Act is amended by striking out "subsection (j)" and inserting in lieu thereof "subsection (h)".

(c) The amendments made by this section shall take effect on January 1, 1981.

PAYMENT TO PROVIDERS OF SERVICES

SEC. 942. Section 1833(a) of such Act is amended by striking out paragraphs (2) and (3) and inserting in lieu thereof the following:

"(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D), (E), and (F) of such section and in paragraph (5) of this subsection and unless otherwise specified in section 1831)—

"(A) with respect to home health services, the reasonable cost of such services, as determined under section 1861(v);

"(B) with respect to other services (except those described in subparagraph (C) of this paragraph), the reasonable costs of such services, as so determined, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such costs;

"(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

"(3) in the case of services described in subparagraphs (D) and (E) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services exceed 80 percent of such costs;

"(4) in the case of facility services described in subparagraph (F) of section 1832(a)(2), the applicable amount described in paragraph (2) of section 1833(i); and

"(5) in the case of preadmission diagnostic services described in section 1861(s)(2)(C) which are furnished to an individual by the outpatient department of a hospital within 7 days of such individual's admission to the same hospital as an inpatient or (to the extent practicable as determined by regulations prescribed by the Secretary) to another hospital, the reasonable costs for such services.".

LIMITATION ON PAYMENTS TO RADIOLOGISTS AND PATHOLOGISTS

SEC. 943. (a) Subsection (a)(1)(B) and (b)(2) of section 1833 of the Social Security Act are each amended by inserting after "pathology" the following: "who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(ii)) for all physicians' services furnished by him to hospital inpatients enrolled under this part".

(b) The amendments made by subsection (a) shall apply to services furnished after the sixth calendar month beginning after the date of the enactment of this Act.

PHYSICIAN TREATMENT PLAN FOR SPEECH PATHOLOGY

SEC. 944. (a) Section 1835(a)(2)(D)(ii) of the Social Security Act is amended by inserting after "established" the following: "by a physician or by the speech pathologist providing such services".

(b) The amendment made by subsection (a) shall apply to plans for furnishing services established on or after January 1, 1981.

REENROLLMENT AND OPEN ENROLLMENT IN PART B

SEC. 945. (a) Subsection (b) of section 1837 of the Social Security Act is repealed.

(b)(1) Subsection (e) of such section is amended to read as follows:

"(e) There shall be a general enrollment period which is any period after the period described in subsection (d).".

(2) Subsection (g)(3) of such section is amended by striking out "the earlier of the then current" and all that follows through "subsection (e) of this section)" and inserting in lieu thereof "the month in which the individual files an application establishing such entitlement".

(c)(1) Section 1838(a)(2)(E) of such Act is amended by striking out "the July 1" and inserting in lieu thereof "the first day of the third month".

(2) The second sentence of subsection (d) of section 1839 of such Act is amended by striking out "who enrolls for the second time) (2)" and all that follows through "in which he enrolled for the second time" and inserting in lieu therof "who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the month after the month in which he reenrolled".

(d) The amendments made by subsections (a), (b), and (c) shall apply to enrollments occurring on or after April 1, 1981.

(e) Section 1843 of the Social Security Act is amended by inserting "or during 1981," in subsections (a), (g)(1), and (h)(1) after "January 1, 1970," each place it appears.

DETERMINATION OF REASONABLE CHARGE

SEC. 946. (a) The third sentence of section 1842(b)(3) of the Social Security Act is amended by striking out "in which the bill is submitted or the request for payment is made" and inserting in lieu thereof "in which the service is rendered".

(b) Such section is further amended by striking out "and" at the end of subparagraph (D), by inserting "and" after the semicolon at the end of subparagraph (E), and by inserting after subparagraph (E) the following new subparagraph:

> *"(F) will take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year (ending on June 30) in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year;"*

(c) The amendments made by subsections (a) and (b) shall become effective with respect to bills submitted or requests for payment made on or after July 1, 1981.

SHORTENED PART B TERMINATION PERIOD FOR CERTAIN INDIVIDUALS WHOSE PREMIUMS MEDICAID HAS CEASED TO PAY

SEC. 947. (a) Section 1843(e) of the Social Security Act is amended by adding at the end thereof the following: "The coverage period under this part of any such individual who (in the last month of his coverage period attributable to the State agreement or in any of the following six months) files notice that he no longer wishes to participate in the insurance program established by this part, shall terminate at the close of the month in which the notice if filed.".

(b) The second sentence of section 1838(b) of such Act is amended by inserting "(except as otherwise provided in section 1843(e))" after "shall".

(c) Section 1843(g)(2) of such Act is amended—

(1) by adding "and" at the end of clause (A);

(2) by striking out " , and" at the end of clause (B) and inserting in lieu thereof a period; and

(3) by striking out clause (C).

(d) The amendments made by this section apply to notices filed after the third calendar month beginning after the date of the enactment of this Act.

(e) The coverage period under part B of title XVIII of the Social Security Act of an individual whose coverage period attributable to a State agreement under section 1843 of such Act is terminated and who has filed notice before the end of the third calendar month beginning after the date of the enactment of this Act that he no longer wishes to participate in the insurance program established by part B of title XVIII shall terminate on the earlier of (1) the day specified in section 1838 without the amendments made by this section, or (2) (unless the individual files notice before the day specified in this clause that he wishes his coverage period to terminate as provided in clause (1)) the day on which his coverage period would terminate if the individual filed notice in the fourth calendar month beginning after the date of the enactment of this Act.

REIMBURSEMENT OF PHYSICIANS' SERVICES IN TEACHING HOSPITALS

SEC. 948. (a)(1) Paragraph (7) of section 1861(b) of the Social Security Act is amended to read as follows:

> *"(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.".*

(2) Section 1832(a)(2)(B)(i)(II) of such Act is amended by striking out ", unless either clause (A) or (B) of paragraph (7) of such section is met" and inserting in lieu thereof "where the conditions specified in paragraph (7) of such section are met".

(b) Section 1842(b) of the Social Security Act is amended by adding at the end the following new paragraph:

"(6)(A) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in sec-

tion 1861(b)(7), the carrier shall not provide (except on the basis described in subparagraph (C)) for payment for such services under this part—

"(i) unless—

"(I) the physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which the payment is sought,

"(II) the services are of the same character as the services the physician furnishes to patients not entitled to benefits under this title, and

"(III) at least 25 percent of the hospital's patients (during a representative past period, as determined by the Secretary) who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) paid all or a substantial part of charges (other than nominal charges) imposed for such services; and

"(ii) to the extent that the amount of the payment exceeds the reasonable charge for the services (with the customary charge determined consistent with subparagraph (B)).

"(B) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

"(i) In the case of a physician who has a substantial practice outside the teaching setting, the carrier shall take into account the amounts the physician charges for similar services in the physician's outside practice.

"(ii) In the case of a physician who does not have a practice described in clause (i), if the hospital, its physicians, or other appropriate billing entity has established one or more schedules of charges which are collected for medical and surgical services, the carrier shall base payment under this title on the greater of—

"(I) the charges (other than nominal charges) which are most frequently collected in full or substantial part with respect to patients who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) of subparagraph (A)(i), or

"(II) the mean of the charges (other than nominal charges) which were collected in full or substantial part with respect to such patients.

"(C) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), if the conditions described in subclauses (I) and (II) of subparagraph (A)(i) are met and if the physician elects payment to be determined under this subparagraph, the carrier shall provide for payment for such services under this part on the basis of regulations of the Secretary governing reimbursement for the services of hospital-based physicians (and not on any other basis).".

(c)(1) The amendments made by subsection (a) shall apply with respect to cost accounting periods beginning on or after October 1, 1978. A hospital's election under section 1861(b)(7)(A) of the Social Security Act (as administered in accordance with section 15 of Public Law 93-233) as of September 30, 1978, shall constitute such

hospital's election under such section (as amended by subsection (a)(1)) on and after October 1, 1978, until otherwise provided by the hospital.

(2) The amendment made by subsection (b) shall apply with respect to cost accounting periods beginning on or after January 1, 1981.

FLEXIBILITY IN APPLICATION OF STANDARDS TO RURAL HOSPITALS

SEC. 949. Section 1861(e) of the Social Security Act is amended by adding the following new sentence at the end thereof: "The term 'hospital' also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in suparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

"(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

"(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facilitity is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients; and (iii) if the Secretary has determined that because of the facility's waiver under this subparagraph the facility should limit its scope of services in order not to adversely affect the health and safety of the facility's patients, the facility is so limiting the scope of services it provides; and

"(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary may (i), waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State

codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequatley protect patients.".

HOSPITAL TRANSFER REQUIREMENT FOR SKILLED NURSING FACILITY COVERAGE

SEC. 950. Section 1861(i) of the Social Security Act is amended—

(1) by striking out "14 days" each place it appears and inserting in lieu thereof "30 days"; and

(2) by striking out ", or (B) within 28 days" and all that follows through "he resides, or (C)" and inserting in lieu thereof ", or (B)".

CERTIFICATION AND UTILIZATION REVIEW BY PODIATRISTS

SEC. 951. (a) Section 1861(r)(3) of the Social Security Act is amended to read as follows: "(3) a doctor of podiatric medicine for the purposes of subsection (s) of this section but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them; and for the purposes of subsections (k) and (m) of this section and sections 1814(a) and 1835 but only if his performance of functions under subsections (k) and (m) and sections 1814(a) and 1835 is consistent with the policy of the institution or agency with respect to which he performs them and with the functions which he is legally authorized to perform,".

(b) Section 1861(k)(2)(A) of such Act is amended by inserting after "two or more physicians" the following: "(of which at least two must be physicians described in subsection (r)(1) of this section)".

(c) The amendments made by this section shall take effect on January 1, 1981.

ACCESS TO BOOKS AND RECORDS OF SUBCONTRACTORS

SEC. 952. Section 1861(v)(1) of the Social Security Act is amended by adding after subparagraph (H) (added by section 930(p) of this title) the following new subparagraph:

"(I) In determining such reasonable cost, the Secretary may not include any costs incurred by a provider with respect to any services furnished in connection with matters for which payment may be made under this title and furnished pursuant to a contract between the provider and any of its subcontractors which is entered into after the date of the enactment of this subparagraph and the value or cost of which is $10,000 or more over a twelve-month period unless the contract contains a clause to the effect that—

"(i) until the expiration of four years after the furnishing of such services pursuant to such contract, the subcontractor shall make available, upon written request to the Secretary, or upon request to the Comptroller General, or any of their duly authorized representatives, the contract, and books, documents and records of such subcontractor that are necessary to certify the nature and extent of such costs, and

"(ii) if the subcontractor carries out any of the duties of the contract through a subcontract, with a value or cost of $10,000

or more over a twelve-month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of four years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request to the Secretary, or upon request to the Comptroller General, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

The Secretary shall prescribe in regulation criteria and procedures which the Secretary shall use in obtaining access to books, documents, and records under clauses required in contracts and subcontracts under this subparagraph.".

MEDICARE LIABILITY SECONDARY WHERE PAYMENT CAN BE MADE UNDER LIABILITY OR NO FAULT INSURANCE

SEC. 953. Section 1862(b) of the Social Security Act is amended—

(1) by inserting "or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance" before the period at the end of the first sentence;

(2) by inserting ", policy, plan, or insurance" before the period at the end of the second sentence; and

(3) by adding at the end the following new sentence: "The Secretary may waive the provisions of this subsection in the case of an individual claim if he determines that the probability of recovery or amount involved in such claim does not warrant the pursuing of the claim.".

PAYMENT FOR PHYSICIANS' SERVICES WHERE BENEFICIARY HAS DIED

SEC. 954. (a) Section 1870(f) of the Social Security Act is amended to read as follows:

"(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and no assignment of the right to payment for such services was made by such individual before his death, and payment for such services has not been made—

"(1) if the person or persons who furnished the services agree that the reasonable charge is the full charge for the services, payment for such services shall be made to such person or persons, and

"(2) if the person or persons who furnished the services do not agree that the reasonable charge is the full charge for the services, payment for such services shall be made on the basis of an itemized bill to the person who has agreed to assume the legal obligation to make payment for such services and files a request for payment (with such accompanying evidence of such legal obligation as may be required in regulations),

but only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.".

(b) The amendment made by this section shall apply only to claims filed on or after January 1, 1981.

PROVIDER REIMBURSEMENT REVIEW BOARD

SEC. 955. Section 1878(f)(1) of the Social Security Act is amended by inserting the following after the second sentence thereof: "Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which such determination is rendered. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing.".

PAYMENT WHERE BENEFICIARY NOT AT FAULT

SEC. 956. (a) Section 1879 of the Social Security Act is amended by adding the following subsection at the end thereof:

"(e) Where payment for inpatient hospital services or extended care services may not be made under part A of this title on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of section 1861 (e) or (j) by such a provider of services acting in good faith in accordance with the advice of a utilization review committee, professional standards review organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary shall take such action with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertent, or erroneous action.".

(b) The amendment made by subsection (a) shall take effect on January 1, 1981.

TECHNICAL RENAL DISEASE AMENDMENTS

SEC. 957. (a) Section 1881(e) of the Social Security Act is amended—

(1) by striking out "and" the first place it appears in paragraph (1) and inserting a comma in lieu thereof;

(2) by inserting "and nonprofit entities which the Secretary finds can furnish equipment economically and efficiently," after "renal dialysis facilities," in paragraph (1);

(3) by striking out "such providers and facilities" and inserting in lieu thereof "such providers, facilities, and nonprofit entities"; and

(4) by striking out "or facility will—" in paragraph (2) and inserting in lieu thereof ", facility, or other entity will—".

(b) Section 1881(g) of such Act is amended by striking out "April" each place it appears and inserting in lieu thereof "July".

STUDIES AND DEMONSTRATION PROJECTS

SEC. 958. (a) The Secretary of Health and Human Services shall develop and carry out a demonstration project to determine (1) the extent to which the commencement of nutritional therapy in early renal failure, utilizing (but not limited to) controlled protein substances, can retard or arrest the progression of the disease with a resultant substantive deferment of dialysis, and (2) the administrative, financial, and other aspects of making such nutritional therapy generally available as part of the benefits received under title XVIII of the Social Security Act.

(b) The Secretary shall submit, to the Congress, within one year after the date of the enactment of this Act, a report on the demonstration projects being conducted by the Secretary with respect to waiving the applicable cost sharing amounts which beneficiaries under title XVIII of the Social Security Act have to pay for obtaining a second opinion on having surgery performed. Such report shall include any recommendations for legislative changes in such title which the Secretary finds desirable as a result of such demonstration projects.

(c) The Secretary shall conduct a study of the circumstances and conditions under which services furnished by registered dietitians should be covered as a home health benefit under title XVIII of the Social Security Act.

(d) The Secretary shall develop and carry out demonstration projects to determine the administrative, financial, and other aspects of making the services of clinical social workers more generally available as part of the benefits received under title XVIII of the Social Security Act.

(e) The Secretary shall, in consultation with appropriate professional organizations, conduct a comprehensive study of methods for providing coverage under part B of title XVIII of the Social Security Act for orthopedic shoes for individuals with disabling or deforming conditions who require special fitting considerations to help protect against increasing disability or serious medical complications or who require special shoes in conjunction with the use of an orthosis or foot support. The Secretary shall submit to the Congress, no later than July 1, 1981, a report on the findings of this study and such specific legislative recommendations as is appropriate with respect to the utilization, cost control, quality of care, and equitable and efficient administration of such an extension of coverage.

(f) The Secretary shall conduct a study of the circumstances and conditions under which services furnished with respect to respiratory therapy should be covered as a home health benefit under title XVIII of the Social Security Act.

(g) The Secretary shall conduct a study involving a comprehensive analysis of the cost effects of alternative approaches to improving

coverage under title XVIII of the Social Security Act for the treatment of various types of foot conditions.

(h) The Secretary shall submit a report on each of the demonstration projects and studies described in subsections (a), (c), (d), (f), and (g). Each such report shall be submitted within twenty-four months of the date of the enactment of this Act and shall contain any recommendations for legislative changes which the Secretary finds desirable as a result of conducting the demonstration project or study with respect to which the report is submitted.

(i) Where any study or demonstration project conducted under this section relates to payments with respect to services furnished by independent practitioners, such study or project shall include an evaluation of the effect such of payments on coordination of care, cost, quality, and the organization in the provision of services and the utilization of services.

(j) Grants, payments under contracts, and other expenditures made for studies and deomnstration projects under this section shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved.

TEMPORARY DELAY ON PERIODIC INTERIM PAYMENTS

SEC. 959. Notwithstanding section 1815(a) of the Social Security Act, in the case of a hospital which is paid periodic interim payments under such section, the Secretary of Health and Human Services shall provide that with respect to the last twenty-one days for which such payments would otherwise be made during fiscal year 1981, such payments shall be deferred until fiscal year 1982.

PART C—PROVISIONS RELATING TO MEDICAID

DISPUTED MEDICAID CLAIMS

SEC. 961. (a) Section 1903(d) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1116(d), and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from

any subsequent payments made to such State under this title, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination (but not to exceed a period of twelve months with respect to disallowances made prior to October 1, 1981, or six months with respect to disallowances made thereafter) at the rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during such period.".

(b) The amendment made by subsection (a) shall be effective with respect to expenditures for services furnished on or after October 1, 1980.

REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITY SERVICES

SEC. 962. (a) Section 1902(a)(13)(E) of the Social Security Act is amended to read as follows:

> *"(E) for payment of the skilled nursing facility and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each skilled nursing or intermediate care facility and periodic audits by the State of such reports; and".*

(b) The amendment made by subsection (a) shall become effective on October 1, 1980.

EXTENSION OF INCREASED FUNDING FOR STATE MEDICAID FRAUD CONTROL UNITS

SEC. 963. Section 1903(a)(6) of the Social Security Act is amended by striking out "an amount equal to" and all that follows through "with respect to costs incurred" and inserting in lieu thereof the following:

> *"an amount equal to—*
>
> > *"(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and*
> >
> > *"(B) 75 per centum of the sums expended during each succeeding calendar quarter,*
>
> *with respect to costs incurred".*

CHANGE IN CALENDAR QUARTER FOR WHICH SATISFACTORY UTILIZATION REVIEW MUST BE SHOWN TO RECEIVE WAIVER OF MEDICAID REDUCTION

SEC. 964. Section 1903(g)(3)(B) of the Social Security Act is amended—

(1) by striking out "October 1, 1977" and inserting in lieu thereof "January 1, 1978"; and

(2) by striking out "the calendar quarter ending on December 31, 1977" and inserting in lieu thereof "any calendar quarter ending on or before December 31, 1978".

REIMBURSEMENT UNDER MEDICAID FOR SERVICES FURNISHED BY NURSE-MIDWIVES

SEC. 965. (a)(1) Subsection (a) of section 1905 of the Social Security Act is amended—

(A) by striking out "and" at the end of paragraph (16);

(B) by redesignating paragraph (17) as paragraph (18); and

(C) by inserting after paragraph (16) the following new paragraph:

"(17) services furnished by a nurse-midwife (as defined in subsection (m)) which he is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not he is under the supervision of, or associated with, a physician or other health care provider; and".

(2) Such section is further amended by adding at the end thereof the following new subsection:

"(m) The term 'nurse-midwife' means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary, and performs services in the area of management of the care of mothers and babies (throughout the maternity cycle) which he is legally authorized to perform in the State in which he performs such services.".

(b) Section 1902(a) of such Act is amended—

(1) by striking out "clauses (1) through (5)" in paragraph (13)(B) and inserting in lieu thereof "paragraphs (1) through (5) and (17)";

(2) by striking out "clauses (1) through (5)" in paragraph (13)(C)(i) and inserting in lieu thereof "paragraphs (1) through (5) and (17)";

(3) by striking out "clauses numbered (1) through (16)" in paragraph (13)(C)(ii) and inserting in lieu thereof "paragraphs numbered (1) through (17)"; and

(4) by striking out "clauses (1) through (5) and (7)" in paragraph (14)(A)(i) and inserting in lieu thereof "paragraphs (1) through (5), (7), and (17)".

(c)(1) The amendments made by this section shall (except as provided under paragraph (2)) be effective with respect to payments under title XIX of the Social Security Act for calendar quarters beginning more than one hundred and twenty days after the date of the enactment of this Act.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and

Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

DEMONSTRATION PROJECTS RELATING TO THE TRAINING OF AFDC RECIPIENTS AS HOME HEALTH AIDES

SEC. 966. (a) The Secretary of Health and Human Services shall enter into agreements with States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of eligible participants as homemakers or home health aides, who shall provide authorized services to elderly or disabled individuals, or other individuals in need of such services, to whom such services, are not otherwise reasonably and actually available or provided, and who would, without the availability of such services, be reasonably anticipated to require institutional care.

(b) For purposes of this section, the term "eligible participant" means an individual who has voluntarily applied for participation and who, at the time such individual enters the project established under this section, has been certified by the appropriate agency of State or local government as being eligible for financial assistance under a State plan approved under part A of title IV of the Social Security Act and as having continuously received such financial assistance during the ninety-day period which immediately precedes the date on which such individual enters such project and who, within such ninety-day period, had not been employed as a homemaker or home health aide.

(c)(1) The Secretary shall enter into agreements under this section with no more than twelve States. Priority shall be given to States which have demonstrated interest in providing services of the type authorized under this section.

(2) A State may apply to enter into an agreement under this section in such manner and at such time as the Secretary may prescribe.

(3) Any State entering into an agreement with the Secretary under this section must—

(A) provide that the demonstration project shall be administered by a State health services agency designated for this purpose by the Governor (which may be the State agency administering or responsible for the administration of the State plan for medical assistance under title XIX of the Social Security Act);

(B) provide that the agency designated pursuant to subparagraph (A) shall, to the maximum extent feasible, arrange for coordinating its activities under the agreement with activities of other State agencies having related responsibilities;

(C) establish a formal training program, which meets such standards as the Secretary may establish to assure the adequacy of such program, to prepare eligible participants to provide part-time and intermittent homemaker services or home health aide

TITLE X—OTHER SOCIAL SECURITY ACT PROGRAMS; UNEMPLOYMENT COMPENSATION

Subtitle A—Public Assistance

FEDERAL DAY CARE REGULATIONS

SEC. 1001. (a) Section 2002(a)(9) of the Social Security Act is amended by adding at the end thereof the following new subparagraph:

"(D) The requirements imposed by this paragraph or by any regulations promulgated by the Department of Health and Human Services to carry out this paragraph shall be inapplicable to child day care services provided after June 30, 1980, and prior to July 1, 1981, which meet applicable standards of State and local law.".

(b) The provisions of section 3(f) of Public Law 93-647 shall not apply with respect to child day care services provided after June 30, 1980, and prior to July 1, 1981, which meet applicable standards of State and local laws.

(c) The Department of Health and Human Services shall assist each State in conducting a systematic assessment of current practices in day care programs funded under title XX of the Social Security Act. Upon completion of such assessments, but not later than June 1, 1981, the Secretary shall provide a summary report of the results of such assessments to the Congress.

ADDITIONAL SAVINGS

SEC. 1002. For provisions of law which reduce spending for fiscal year 1981 under public assistance programs under the Social Security Act in satisfaction of reconciliation requirements imposed by sections 3(a)(8) and 3(a)(15) of H. Con. Res. 307 (96th Congress), see the Social Security Disability Amendments of 1980 (Public Law 96-265) and the Adoption Assistance and Child Welfare Act of 1980 (Public Law 95-272).

Subtitle B—Old-Age, Survivors, and Disability Insurance Program

LIMIT ON RETROACTIVE BENEFITS

SEC. 1011. (a) The first sentence of section 202(j)(1) of the Social Security Act is amended by striking out "prior to the end of the twelfth month immediately succeeding such month." and inserting in lieu thereof the following: "prior to—

"(A) the end of the twelfth month immediately succeeding such month in any case where the individual (i) is filing application for a benefit under subsection (e) or (f), and satisfies paragraph (1)(B) of such subsection by reason of clause (ii) thereof, or (ii) is filing application for a benefit under subsection (b), (c), or (d) on the basis of the wages and self-employment income of a person entitled to disability insurance benefits, or

"(B) the end of the sixth month immediately succeeding such month in any case where subparagraph (A) does not apply.".

(b) The amendment made by subsection (a) shall be effective with respect to applications on or after the first day of the first month which begins 60 days or more after the date of the enactment of this Act.

ADDITIONAL SAVINGS

SEC. 1012. For provisions of law which reduce spending for fiscal year 1981 under the old-age, survivors, and disability insurance program in sstisfaction of reconciliation requirements imposed by sections 3(a)(8) and 3(a)(15) of H. Con. Res. 307 (96th Congress), see section 5 of Public Law 96-473, and the Social Security Disability Amendments of 1980 (Public Law 96-265).

Subtitle C—Unemployment Compensation Provisions

TERMINATION OF PROVISIONS PROVIDING REIMBURSEMENT FOR UNEMPLOYMENT BENEFITS PAID ON THE BASIS OF PUBLIC SERVICE EMPLOYMENT

SEC. 1021. Part B of title II of the Emergency Jobs and Unemployment Assistance Act of 1974 is amended by adding at the end thereof the following new section:

"TERMINATION

"SEC. 224. Notwithstanding any other provision of this part, the term 'public service wages' shall not include remuneration for services performed in weeks which begin after the date of the enactment of this section."

WAITING PERIOD FOR BENEFITS

SEC. 1022. (a) Section 204(a)(2) of the Federal-State Extended Unemployment Compensation Act of 1970 is amended—

(1) by inserting "(A)" after "compensation", and

(2) by inserting immediately before the period the following: ", or (B) paid for the first week in an individual's eligibility period for which extended compensation or sharable regular compensation is paid, if the State law of such State provides for payment (at any time or under any circumstances) of regular compensation to an individual for his first week of otherwise compensable unemployment".

(b)(1) Except as provided in paragraph (2), the amendments made by this section shall apply in the case of compensation paid to individuals during eligibility periods beginning on or after the date of the enactment of this Act.

(2) In the case of a State with respect to which the Secretary of Labor has determined that State legislation is required in order to eliminate its current policy of paying regular compensation to an individual for his first week of otherwise compensable unemployment, the amendments made by this section shall apply in the case of compensation paid to individuals during eligibility periods beginning after the end of the first regularly scheduled session of the State leg-

islature ending more than thirty days after the date of the enactment of this Act.

BENEFITS ON ACCOUNT OF FEDERAL SERVICE TO BE PAID BY EMPLOYING FEDERAL AGENCY

SEC. 1023. (a) Title IX of the Social Security Act is amended by adding at the end thereof the following new section:

"FEDERAL EMPLOYEES COMPENSATION ACCOUNT

"Sec. 909. There is hereby established in the Unemployment Trust Fund a Federal Employees Compensation Account which shall be used for the purposes specified in section 8509 of title 5, United States Code. For the purposes provided for in section 904(e), such account shall be maintained as a separate book account.".

(b) Subchapter I of chapter 85, title 5, United States Code, is amended by adding at the end thereof the following new section:

"§ 8509. Federal Employees Compensation Account

"(a) The Federal Employees Compensation Account (as established by section 909 of the Social Security Act, and hereafter in this section referred to as the 'Account') in the Unemployment Trust Fund (as established by section 904 of such Act) shall consist of—

"(1) funds appropriated to or transferred thereto, and

"(2) amounts deposited therein pursuant to subsection (c).

"(b) Moneys in the Account shall be available only for the purpose of making payments to States pursuant to agreements entered into under this subchapter and making payments of compensation under this subchapter in States which do not have in effect such an agreement.

"(c)(1) Each employing agency shall deposit into the Account amounts equal to the expenditures incurred under this subchapter on account of Federal service performed by employees and former employees of that agency.

"(2) Deposits required by paragraph (1) shall be made during each calendar quarter and the amount of the deposit to be made by any employing agency during any quarter shall be based on a determination by the Secretary of Labor as to the amounts of payments, made prior to such quarter from the Account based on Federal service performed by employees of such agency after December 31, 1980, with respect to which deposit has not previously been made. The amount to be deposited by any employing agency during any calendar quarter shall be adjusted to take account of any overpayment or underpayment of deposit during any previous quarter for which adjustment has not already been made.

"(d) The Secretary of Labor shall certify to the Secretary of the Treasury the amount of the deposit which each employing agency is required to make to the Account during any calendar quarter, and the Secretary of the Treasury shall notify the Secretary of Labor as to the date and amount of any deposit made to such Account by any such agency.

"(e) Prior to the beginning of each fiscal year (commencing with the fiscal year which begins October 1, 1981) the Secretary of Labor shall estimate—

"(1) the amount of expenditures which will be made from the Account during such year, and

"(2) the amount of funds which will be available during such year for the making of such expenditures,

and if, on the basis of such estimate, he determines that the amount described in paragraph (2) is in excess of the amount necessary—

"(3) to meet the expenditures described in paragraph (1), and

"(4) to provide a reasonable contingency fund so as to assure that there will, during all times in such year, be sufficient sums available in the Account to meet the expenditures described in paragraph (1),

he shall certify the amount of such excess to the Secretary of the Treasury and the Secretary of the Treasury shall transfer, from the Account to the general fund of the Treasury, an amount equal to such excess.

"(f) The Secretary of Labor is authorized to establish such rules and regulations as may be necessary or appropriate to carry out the provisions of this section.

"(g) Any funds appropriated after the establishment of the Account, for the making of payments for which expenditures are authorized to be made from moneys in the Account, shall be made to the Account; and there are hereby authorized to be appropriated to the Account, from time to time, such sums as may be necessary to assure that there will, at all times, be sufficient sums available in the Account to meet the expenditures authorized to be made from moneys therein.".

(c) All funds appropriated which are available for the making of payments to States after December 31, 1980, pursuant to agreements entered into under subchapter I of chapter 85 of title 5, United States Code, or for the making of payments after such date of compensation under such subchapter in States which do not have in effect such an agreement, shall be transferred on January 1, 1981, to the Federal Employees Compensation Account established by section 909 of the Social Security Act. On and after such date, all payments described in the preceding sentence shall be made from such Account as provided by section 8509 of title 5, United States Code.

LIMITATION ON EXTENDED UNEMPLOYMENT COMPENSATION PROGRAM

SEC. 1024. (a) Section 202(a) of the Federal-State Extended Unemployment Compensation Act of 1970 is amended by adding at the end thereof the following new paragraphs:

"(3)(A) Notwithstanding the provisions of paragraph (2), payment of extended compensation under this Act shall not be made to any individual for any week of unemployment in his eligibility period—

"(i) during which he fails to accept any offer of suitable work (as defined in subparagraph (c)) or fails to apply for any suitable work to which he was referred by the State agency; or

"(ii) during which he fails to actively engage in seeking work.

"(B) If any individual is ineligible for extended compensation for any week by reason of a failure described in clause (i) or (ii) of subparagraph (A), the individual shall be ineligible to receive extended compensation for any week which begins during a period which—

"(i) begins with the week following the wek in which such failure occurs, and

(2) TECHNICAL AND CONFORMING AMENDMENTS.—The table of sections for subpart B of chapter 65 of such code is amended by adding at the end thereof the following new item:

"Sec. 6429. Credit and refund of chapter 45 taxes paid by royalty owners."

(b) DENIAL OF DEDUCTION.—

(1) IN GENERAL.—Part IX of subchapter B of chapter 1 of such Code (relating to items not deductible) is amended by adding at the end thereof the following new section:

"SEC. 280D. PORTION OF CHAPTER 45 TAXES FOR WHICH CREDIT OR REFUND IS ALLOWABLE UNDER SECTION 6429.

"No deduction shall be allowed for that portion of the tax imposed by section 4986 for which a credit or refund is allowable under section 6429."

(2) CONFORMING AMENDMENT.—The table of sections for part IX of subchapter B of chapter 1 of such Code is amended by adding at the end thereof the following new item:

"Sec. 280D. Portion of chapter 45 taxes for which credit or refund is allowable under section 6429."

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years ending after February 29, 1980.

Subtitle E—Inclusion in Wages for Purposes of Social Security and Unemployment Taxes of Employer

SEC. 1141. INCLUSION IN WAGES OF EMPLOYEE TAXES PAID BY EMPLOYER.

(a) SOCIAL SECURITY TAX.—

(1) AMENDMENT OF INTERNAL REVENUE CODE OF 1954.—Paragraph (6) of section 3121(a) of the Internal Revenue Code of 1954 (defining wages) is amended to read as follows:

"(6) the payment by an employer (without deduction from the remuneration of the employee)—

"(A) of the tax imposed upon an employee under section 3101, or

"(B) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;".

(2) AMENDMENT OF SOCIAL SECURITY ACT.—Subsection (f) of section 209 of the Social Security Act is amended to read as follows:

"(f) The payment by an employer (without deduction from the remuneration of the employee)—

"(1) of the tax imposed upon an employee under section 3101 of the Internal Revenue Code of 1954, or

"(2) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;".

(b) FEDERAL UNEMPLOYMENT TAX.—Paragraph (6) of section 3306(b) of the Internal Revenue Code of 1954 (defining wages) is amended to read as follows:

"(6) the payment by an employer (without deduction from the renumeration of the employee)—

"(A) of the tax imposed upon an employee under section 3101, or

"(B) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;".

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply with respect to remuneration paid after December 31, 1980.

(2) EXCEPTION FOR STATE AND LOCAL GOVERNMENTS.—

(A) the amendments made by this section (insofar as they affect the application of section 218 of the Social Security Act) shall not apply to any payment made before January 1, 1984, by any governmental unit for positions of a kind for which all or a substantial portion of the social security employee taxes were paid by such governmental unit (without deduction from the remuneration of the employee) under the practices of such governmental unit in effect on October 1, 1980.

(B) For purposes of subparagraph (A), the term "social security employee taxes" means the amount required to be paid under section 218 of the Social Security Act as the equivalent of the taxes imposed by section 3101 of the Internal Revenue Code of 1954.

(C) For purposes of subparagraph (A), the term "governmental unit" means a State or political subdivision thereof within the meaning of section 218 of the Social Security Act.

Subtitle F—Telephone Tax

SEC. 1151. TELEPHONE TAX CONTINUED AT 2 PERCENT FOR 1981.

(a) IN GENERAL.—The table contained in paragraph (2) of section 4251(a) of the Internal Revenue Code of 1954 (relating to imposition of tax on communication services) is amended by striking out the last 2 lines of such table and inserting in lieu thereof the following:

"During 1980 or 1981	2
"During 1982	1".

(b) CONFORMING AMENDMENT.—Subsection (b) of section 4251 of such Code is amended by striking out "January 1, 1982" and inserting in lieu thereof "January 1, 1983".

Subtitle G—Increase Until 1993 in the Duties on Certain Imports of Ethyl Alcohol

SEC. 1161. INCREASE UNTIL 1993 IN THE DUTIES ON ETHYL ALCOHOL IMPORTED FOR FUEL USE.

(a) AMENDMENTS TO APPENDIX TO TSUS.—

(1) FOR 1981.—Effective with respect to articles entered on or after January 1, 1981, subpart A of part 1 of the Appendix to

I. HEALTH PROVISIONS

1. Home health services

House bill.—The House bill provides medicare coverage for unlimited home health visits; eliminates the 3-day prior hospital stay requirement under part A of medicare; eliminates the $60 deductible for home health benefits under part B; includes the need for occupational therapy as a qualifying criterion for home health benefits; allows proprietary home health agencies in states without licensure laws to participate in medicare; provides authority for the Secretary of Health and Human Services to require bonding or the establishing of escrow accounts to the extent he finds necessary; requires the Secretary to establish regional intermediates for home health agencies; and requires the Secretary to take several actions to achieve the more effective administration of the home health benefit.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill.

The conference agreement eliminates the special licensing requirement under present medicare law relating to proprietary home health agencies and the authority of the Secretary to establish additional standards solely on the basis of the tax status of an agency. Thus, under the conference agreement, if a state has a home health agency licensing law, any home health agency, regardless of its sponsorship, must be licensed under that law or be approved by the state agency responsible for licensing home health agencies as meeting the established requirements (other than requirements relating to the tax status of the agency) in order to participate as a home health agency in the medicare program.

In requiring the designation of regional intermediaries for home health agencies, it is not the intent of the conferees that home health agencies would be precluded from contracting directly with the Health Care Financing Administration.

2. Reciprocal agreements for services furnished outside the United States

House bill.—The House bill authorizes the negotiation of reciprocal agreements with other countries for medicare benefits for beneficiaries living or traveling outside the United States.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

3. Dentists' services

House bill.—The House bill provides medicare coverage for services furnished by dentists when the services are of the kinds that are covered when furnished by physicians. The bill also covers hospital stays where the severity of the noncovered dental procedure warrants. Routine dental services would continue to be noncovered services.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

4. Treatment of plantar warts

House bill.—The House bill provides medicare coverage for the treatment of plantar warts (warts on the feet).

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

5. Community mental health centers

House bill.—The House bill provides reimbursement under part B of medicare to community mental health centers for up to 15 outpatient and 60 partial hospitalization visits per year under part B of medicare.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

6. Comprehensive outpatient rehabilitation facility services

House bill.—The House bill covers free-standing outpatient rehabilitation facilities as providers of services under medicare.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

7. Optometrists' services

House bill.—The House bill covers services furnished by optometrists related to the condition of aphakia (absence of the natural lens of the eye).

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

8. Antigens

House bill.—The House bill covers antigens prepared by one physician and forwarded to another for administration to the patient.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

9. Payment where beneficiary not at fault

House bill.—The House bill requires the Secretary to make medicare payment where a beneficiary who required a higher level of care was erroneously placed in a part of the institution providing a lower level of care.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

10. Flexibility in application of standards to rural hospitals

House bill.—The House bill authorizes the Secretary to apply the medicare health and safety standards applicable to all hospitals

more flexibly with respect to rural hospitals where such action will not jeopardize patient health and safety.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision with a modification under which the Secretary is authorized to provide for a limitation on the scope of services to be furnished by a hospital consistent with any relaxation or waiver of applicable standards.

11. Certification and utilization review by podiatrists

House bill.—The House bill allows podiatrists, acting within the scope of their practice, to be recognized as physicians for the purpose of physician certification and utilization review.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

12. Physician treatment plan for speech pathology

House bill.—The House bill allows a speech pathologist to establish the plan of treatment for speech pathology services.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

13. Payment for physicians' services where beneficiary has died

House bill.—The House bill authorizes, for physicians' services rendered to a beneficiary before his death, payment on the basis of an unpaid bill, to the person who has agreed to assume legal obligation to pay the physician.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

14. Presumed coverage provisions

House bill.—The House bill repeals medicare provisions authorizing, by type of diagnosis, presumed periods of coverage for skilled nursing facility and home health services.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

15. Payments to providers of services

House bill.—The House bill (a) repeals a provision of existing law under which medicare payments to a provider of services are limited to the lower of the provider's customary charges or the reasonable cost for services to medicare beneficiaries, and (b) providers for reimbursement under medicare Part B to providers of services on the basis of the reasonable cost minus the coinsurance amounts charged beneficiaries.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision on (a) and follows the House provision on (b).

16. Limit on premium increases due to late enrollment

House bill.—The House bill limits the late enrollment penalty under medicare part B to a maximum of 30 percent.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

17. Reenrollment and open enrollment in part b

House bill.—The House bill repeals a provision of existing law that permits beneficiaries to reenroll in medicare Part B only once (thus unlimited reenrollment would be permitted), and also permits continuous open enrollment for individuals who failed to enroll at their first opportunity (rather than open enrollment only during January through March of each year).

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision with a modification providing a one-year period beginning January 1, 1981, during which any State which has not already done so could enter into an agreement or modification of an agreement, with the Secretary under section 1843 of the Social Security Act for the enrollment of, and purchase of medicare Part B protection for, eligible individuals who are receiving money payments under public assistance programs or who are eligible for medical assistance under title XIX of the Social Security Act. A state currently without a buy-in agreement could enter into an agreement during 1981 covering both cash recipients and persons eligible only for medical assistance if it wished to do so.

18. Chiropractors' services

House bill.—The House bill modifies the requirement for chiropractic coverage so that a subluxation could be domonstrated to exist either by an X-ray or other chiropractic clinical findings. X-rays taken to demonstrate a subluxation would be covered.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

19. Increase in outpatient mental health benefits under part B

House bill.—The House bill increases the present limit on reimbursement for outpatient mental health services from 50 to 80 percent of reasonable charges, up to $750 in program payments per year. The bill also covers outpatient services of qualified clinical psychologists when referred by a physician.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

20. Limitation of payments to radiologists and pathologists

House bill.—The House bill limits the special 100 percent reimbursement for radiology and pathology services to physicians accepting assignment for all services furnished to hospital inpatients.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

21. Shortened part B termination period for certain individuals whose premiums medicaid has ceased to pay

House bill.—The House bill permits an individual whose State buy-in coverage for part B of medicare has ended to terminate such coverage effective with the month medicare is notified that coverage is no longer wanted, rather than continue, enrollment for as long as 6 months.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

22. Outpatient physical therapy services

House bill.—The House bill increases the present $100 yearly limitation on outpatient physical therapy services to $500.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

23. Reimbursement for blood

House bill.—The House bill eliminates the medicare 3-pint blood deductible.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

24. Medicare payment liability secondary in certain automobile insurance cases

House bill.—The House bill provides that medicare would be the secondary payor in any case where the health care services can be paid for under an automobile insurance policy. And under present law with respect to workmen's compensation cases, medicare would pay the beneficiary's claim and recover the amounts payable from the private insurance company when liability for such payment is established.

Senate amendment.—The Senate amendment contains a similar provision except that (a) medicare would be the secondary payor in any case where care can be paid for under any liability insurance policy (including an automobile insurance policy) or under a no-fault insurance plan; and (b) the Secretary is authorized to waive this provision if he determines that the probability of recovery or the amount involved under such a policy or plan does not warrant the pursuing of the claim.

Conference agreement.—The conference agreement follows the Senate amendment with modifications to clarify that the provision (a) is also applicable to self-insurance plans, and (b) will be administered, with respect to the recovery of amounts payable under a plan or policy, as provided for in the House bill. With respect to no-fault insurance plans, the provision is applicable only to the policies or plans actually held by the individuals involved and not to any hypothetical policies or plans that an individual at one time could have opted, but did not opt, to enroll in.

25. Hospital transfer requirement for skilled nursing facility coverage

House bill.—The House bill provides that the 14-day period within which a medicare beneficiary must be transferred from a hospital to a skilled nursing facility in order to qualify for post-hospital extended care benefits would be extended to 30 days. The bill also extends the period during which beneficiaries can be readmitted to a skilled nursing facility without again meeting the three day prior hospitalization requirement.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

26. Outpatient surgery

House bill.—The House bill requires the Secretary to establish a list of procedures which, although appropriately performed on a hospital inpatient basis, can also be safely performed in an ambulatory surgical center. The costs related to the use of the ambulatory surgical center in performing such procedures would be covered in full. Medicare would also reimburse 100 percent of the physician's reasonable charge when he performs such procedures in an ambulatory surgical center or in the outpatient department of a hospital, provided the physician agrees to accept assignment.

Senate amendment.—The Senate amendment requires the Secretary to establish lists of procedures which can be safety and appropriately performed both on a hospital inpatient basis and in an ambulatory surgical center or a physician's office. The costs related to performing procedures in an ambulatory surgical center would be covered in full. An amount calculated to take account of any unusual overhead expenses would be established and paid where a physician performs the specified procedures in his office. The physician's fee for performing such procedures in an ambulatory surgical center, the outpatient department of a hospital, or in the office would be reimbursed 100 percent of the reasonable charge provided the physician agreed to accept assignment.

Conference agreement.—The conference agreement generally follows the Senate amendment with modifications. The Secretary is to establish (a) a list of procedures which are frequently performed on a hospital inpatient basis but which can be safely performed in an ambulatory surgical center and (b) a list of procedures which are frequently performed on a hospital inpatient basis but can also be safely performed in a physician's office. The purpose of this provision is to provide incentives to perform surgical procedures on a less costly outpatient basis in cases where the need to perform the procedure is routinely used as justification for admission as a hospital inpatient. Accordingly, it is not expected that the lists established by the Secretary would include procedures which are already generally recognized as more appropriately (from the standpoint of efficient utilization of inpatient services) performed on an outpatient basis.

For those procedures which can be performed in a physician's office, an amount calculated to take account of any unusual overhead expense not usually incorporated into the professional fee for equipment, supplies, space, etc., would be established and paid in full. This overhead factor is expected to be calculated on a prospec-

tive basis (and periodically updated) utilizing sample survey or similar techniques to establish reasonable estimated overhead allowances for each of the listed procedures which take account of volume (within reasonable limits). The Secretary is expected to recognize only such additional overhead expenses as are not reflected in the customary charges of physicians.

Subject to the conditions discussed below, the physician would be reimbursed 100 percent of the reasonable charge for performing the listed procedures, provided he accepts assignment, in an ambulatory surgical center, the outpatient department of a hospital, or his office.

This reimbursement would be authorized for procedures performed in the physicians' offices only where (1) a Professional Standards Review Organization is willing, able, and has agreed to carry out a review of the physician performance of such procedures and (2) the physician has agreed to make such records available to the PSRO as may be determined to be necessary. Further, physicians would be reimbursed under this section only for those procedures for which they have admitting privileges in a hospital located in the geographic area in which their office is located.

27. Technical renal disease amendments

House bill.—The House bill authorizes the Secretary to enter into agreements with approved non-profit organizations to assist home dialysis patients in obtaining and maintaining dialysis equipment; changes the reporting date for the renal disease program annual report from April 1 to July 1; and provides that the State health planning agency's determination, rather than the Secretary's, of the need for a new or expanded renal facility is conclusive.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House provisions relating to agreements with non-profit organizations assisting home dialysis patients and to the change in the reporting date for the annual renal disease program report; but does not include the House provision relating to determinations of the need for a new or expanded renal facility.

The conferees recognize that every effort should be made to coordinate renal dialysis facility certification by the Secretary with the certificate of need approval process. Accordingly, it is expected that the Secretary will take appropriate steps tc inform State health planning agencies and potential applicants of the criteria for certification of renal dialysis facilities.

28. Preadmission diagnostic testing

House bill.—The House bill provides 100 percent medicare reimbursement for diagnostic tests administered in the outpatient department of a hospital seven days prior to the patient's treatment as a hospital inpatient.

Senate amendment.—The Senate amendment provides for 100 percent reimbursement for those diagnostic tests which are designated by the Secretary as tests which can be performed either on an inpatient or outpatient basis if the tests are administered in the outpatient department of a hospital seven days prior to the patient's treatment as a hospital surgical inpatient.

Conference agreement.—The conference agreement follows the House provision with an amendment to cover, to the extent practicable, diagnostic tests administered in a physician's office seven days prior to admission as an inpatient. The conferees intend that, in determining whether coverage for diagnostic tests furnished in a physician's office is feasible, the Secretary is to consider whether such an arrangement is administratively practical and appropriate procedures can be established between the part A intermediary and the part B carrier, whether it contributes to the economical use of program funds, whether adequate protections against possible abuse are included, and whether there are assurances that the tests are transferable and won't be duplicated.

29. Studies and demonstration projects

House bill.—The House bill provides for studies with respect to medicare coverage for orthopedic shoes, respiratory therapy, second opinions for surgery, foot care, and home health services of dieticians. Demonstration projects are authorized with respect to coverage for clinical social workers and nutritional therapy for renal patients.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision with an amendment to provide that, where relevant, any study undertaken under this provision should include an evaluation of the effects of payments to independent practitioners on coordination of care, cost, quality, organized settings, and utilization of services.

30. Provider Reimbursement Review Board

House bill.—The House bill requires the Board, when requested by a provider, to determine within 30 days whether it has jurisdiction over an issue brought before it by a provider; authorizes the Board to make such determinations on its own motion; and authorizes judical review without further administrative review where the Board decides it lacks jurisdiction.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

31. Access to books and records of subcontractors

House bill.—The House bill provides that medicare reimbursement will include amounts paid by providers for services furnished under contracts with subcontractors whose cost or value over 12 months is at least $10,000 only if such contracts contain a provision allowing the Secretary or the Comptroller General access, upon request, to the contract, and the books, documents, and records of the subcontractor that are necessary to verify costs. Such access would need to be provided for 3 years after furnishing of the services.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision with several modifications: (1) Access to books and records would be required for 4 years rather than 3 years after furnishing of the services; (2) contracts between providers and subcontractors would require that if the subcontractor carries out any of the duties under the contract through an organization related to

the subcontractor by common ownership or control, the subcontractor's contract with the related organization must provide for similar access to books and records; (3) the Secretary's request for access to books and records must be in writing; and (4) the Secretary would be required to specify in regulations the criteria and procedures for seeking and obtaining access to the relevant contracts, books, documents and records. (The intent of provisions (3) and (4) is to assure that subcontractors will not be subjected to inappropriate requests.) In addition, under the conference agreement, the provisions specifying a cost or value of at least $10,000 are intended as a measure of significant business activity between a provider and a single subcontractor (or between a subcontractor and another related subcontractor), and this measure could not be appropriately circumvented by entering into a series of smaller contracts each of which is for less than $10,000. The conferees would further note that, in the event a subcontractor or a related organization does not include the required provision in contracts to which this provision is applicable, or if they refuse to provide access under such provision, the Secretary or Comptroller General could, in addition to any other remedies available to them, initiate legal action against such subcontractor or organizations as intended third party beneficiaries.

32. Medicare coverage of pneumococcal vaccine and its administration

House bill.—The House bill authorizes medicare reimbursement for pneumococcal vaccine and its administration with no applicable deductible or coinsurance.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include for House provision.

33. Expanded membership of professional standards review organizations

House bill.—The House bill authorizes each PSRO to offer membership, at its own option, to nonphysician health professionals who hold independent hospital admitting privileges.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

34. Registered nurse and dentist membership on statewide council advisory group

House bill.—The House bill provides that at least one registered professional nurse and one dentist must be included in the membership of the advisory group to each Statewide PSRO Council.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

35. Nonphysician membership on National Professional Standards Review Council

House bill.—The House bill expands the membership of the National Council to include a dentist, a registered professional nurse

and one other nonphysician health professional representing the recognized ancillary health care disciplines.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

36. Efficiency in delegated review

House bill.—The House bill authorizes PSRO's to delegate review functions to hospitals only if the hospital demonstrates a capacity to carry out the required reviews effectively, efficiently and in a timely fashion.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

37. Required activities of PSRO's

House bill.—The House bill provides that, in order to obtain full designation, a conditionally designated PSRO must be satisfactorily conducting reviews of inpatient services provided by hospitals in its areas, except that review of ancillary services is not required. (The House bill eliminates the requirement of present law that a PSRO must be reviewing outpatient hospital services and long-term care services to be fully designated.) The bill also directs the Secretary to establish a program for the evaluation of the cost-effectiveness of PSRO review of particular types of services and authorizes the Secretary to require PSRO's to conduct review of additional types of services only where such review has been found to be cost-effective or yields other significant benefits.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

38. Response of PSRO's to Freedom of Information Act requests

House bill.—The House bill provides that no PSRO will be required to make available any records pursuant to a request under the Freedom of Information Act (FOIA) until 180 days after the entry of a final court order requiring such disclosure.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House provisions with a modification under which a PSRO will not be required to make records available pursuant to an FOIA request until the later of: (1) one year after the entry of a final court order requiring such disclosure, or (2) the last date of the Congress during which the court order was entered. The intent of the conference agreement on this provision is not to make moot or otherwise reflect congressional intent with respect to any cases on the issue of PSRO disclosure of information under the FOIA now pending before the courts, but rather to provide time for the Congress to have the benefit of full judicial consideration of the issue.

39. Consultation by PSRO's with health care practitioners

House bill.—In lieu of the present requirement of formal advisory groups of health care practitioners to individual PSRO's, the House bill authorizes the Secretary to establish more flexible

guidelines to assure appropriate operational PSRO consultation with representatives of all health care disciplines.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

40. Review of routine hospital admission services and preoperative stays by PSRO's

House bill.—The House bill authorizes PSRO's to focus preadmission review on those areas of relatively frequent overutilization—particulary routine hospital admission services and excessive preoperative stays—to assure that program payments are made only when routine tests and long preoperative stays for elective conditions are medically appropriate. The House bill also authorizes the Secretary to direct a PSRO to conduct such reviews where the Secretary determines they can be made on a timely, cost-effective basis.

Senate amendment.—The Senate amendment contains a similar provision directing PSRO's to give priority to the review of routine hospital admission services and preoperative stays.

Conference agreement.—The conference agreement includes the House provision.

41. Study of PSRO norms, standards, and criteria

House bill.—The House bill requires the Secretary to conduct, in consultation with the National Council, a nationwide study of the differences in PSRO norms and to report the findings to Congress within one year of enactment.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

42. Nonprofit hospital philanthropy

House bill.—The House bill provides that grants, gifts, and income from endowments, whether restricted by the donor or not (as well as certain income from philanthropic gifts, and other funds) shall not be deducted from operating costs of nonprofit hospitals in determining reimbursement under the medicare, medicaid and Maternal and Child Health programs.

Senate amendment.—No provision.

Conference agreement.—The conference agreement modifies the House provision to specify that the following items shall not be deducted from the operating costs of nonprofit hospitals in determining reimbursement amounts: (1) grants, gifts or endowments, and the income therefrom, which have not been designated by the donor for paying any specific operating costs; (2) governmental grants or similar payments, under the terms of which the grant or payment is not available for use as operating funds; and (3) the proceeds from the sale or mortgage of any real estate or other capital asset which the hospital acquired through gift or grant and which, under the terms of the gift or grant, are not available for use as operating funds (except for recovery of the appropriate share of depreciation when gains or losses are realized from the disposal of depreciable assets.)

In determining reimbursement amounts, the Secretary would continue to have authority not to deduct from operating costs certain types of donor-designated gifts and grants (including government grants) if he or she determines that it would be in the best interest of needed health care not to make a deduction with respect to such types of grants or gifts. It is intended the exemption currently contained in regulations relating to family practice training grants would be continued.

It is the intent of the conference committee that the prohibition against deducting gifts, grants, endowments, and income therefrom, shall apply indirectly as well as directly and preclude the Secretary from taking into account the presence of charitable funds generated from gifts, grants or endowments which have not been designated by the donor for paying any specific operating costs as a reason for denying any reimbursable expense, such as interest expense.

43. Consultative services for skilled nursing facilities

House bill.—The House bill repeals the provision of present law under which the State agency responsible for determining skilled nursing facility compliance with medicare's conditions of participation may furnish consultative services to help the facility achieve or maintain compliance with the conditions of participation.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

44. Study of need for dual participation of skilled nursing facilities

House bill.—The House bill requires the Secretary to conduct a study of the reasons for the present scarcity of skilled nursing home beds, including the extent to which existing law and regulations discourage dual participation of skilled nursing facilities in the medicare and medicaid programs, and to report the results of the study to Congress within one year after enactment.

Senate amendment.—No provision.

Conference Agreement.—The conference agreement includes the House provision.

45. Alternative to decertification of long-term care facilities out of compliance with conditions of participation; look behind authority

House bill.—The House bill authorizes the Secretary and State medicaid agencies to deny reimbursement for services furnished by a skilled nursing facility or an intermediate care facility for all medicare and medicaid beneficiaries admitted to the facility after the date the Secretary determines that such facility is substantially out of compliance with the conditions of participation. This intermediate sanction would be applicable as an alternative to decertification only in the case of a facility whose deficiencies do not immediately jeopardize the health and safety of patients; where patient health and safety is jeopardized, the Secretary and the State agency are required to take action to decertify the facility simultaneously with application of the more limited sanction. (The provision requires the Secretary to provide public notification to poten-

tially affected beneficiaries of the date of the sanction and the fact that no benefits will be payable on behalf of a beneficiary admitted to the facility after that date.) In addition, this provision authorizes the Secretary to "look behind" a State's survey of an SNF or ICF and, where the Secretary finds that a facility does not meet the conditions of participation, to terminate that facility's participation in medicaid.

Senate amendment.—No provision.

Conference agreement.—The conference agreement included the House provision with a modification limiting the Secretary's authority to "look behind" a State's survey of a SNF or ICF to situations in which the Secretary has cause to question the adequacy of the State's determination. It is understood that cause for questioning the State's determination could include the general performance of the State system or complaints by residents, relatives, advocates or others about the quality of care or conditions in the facility. Under the Conference agreement it is intended that Federal financial participation could be continued with respect to medicaid patients of a facility decertified by the Secretary during such reasonable time as is required to effect the transfer of medicaid patients from the facility. Further, the conferees note that it is not the intention of this provision to alter the access to a full evidentiary hearing before decertification of a facility occurs, as provided under current law.

46. Life Safety Code requirements

House bill.—The House bill repeals the requirement that skilled nursing facilities must be in compliance with the 1973 edition of the Life Safety Code of the National Fire Protection Association and authorizes the Secretary to determine in regulations when facilities are to be required to meet the provisions of revised editions of the Code, taking into account the capabilities of facilities and State survey agencies to accommodate the revisions.

Senate amendment.—No provision.

Conference agreement.—The conference agreement included the House provisions with a modification to provide that facilities which are in compliance with the Life Safety Code provisions of present law (and for so long as such compliance is maintained) will be considered to be in compliance with the requirements imposed in regulations with respect to the Life Safety Code provisions.

47. Criminal standards for certain medicare and medicaid related crimes.

House bill.—The House bill provides that the criminal penalities under present law for the solicitation, payment or receipt of remuneration for referring a medicare or medicaid patient or in return for purchasing, leasing or ordering any supply or service covered under medicare or medicaid will be applicable where such conduct is undertaken knowingly or willfully.

Senate amendment.—No provision.

Conference agreement.—The conference agreement included the House provision.

48. Exclusion of health care professionals convicted of medicare or medicaid-related crimes

House bill.—The House bill broadens the exclusion under present law from participation in medicare and medicaid of practitioners convicted of program-related crimes so as to apply this provision to all other categories of health professionals.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision with a modification that would make the provision applicable to the program under Title XX of the Social Security Act.

49. Requirements concerning reporting of financial interest

House bill.—The House bill amends the financial reporting requirements of present law (under which reporting of all interests of 5 percent or more of any obligations secured by the entity if required) to provide that an entity must report only those individual interests in mortgages or other obligations equal to at least $25,000 or 5 percent of the entity's total assets.

Senate bill.—No provision.

Conference agreement.—The conference agreement includes the House provision.

50. Withholding of Federal share of payments to medicaid providers to recover medicaid overpayments

House bill.—The House bill authorizes the Secretary to withhold the Federal share of medicaid payments from providers and physicians in order to recover medicare overpayments where such overpayments cannot be recovered through the medicare program either because the provider is participating in medicare at a minimal level or the physician no longer accepts assignment for medicare claims.

Senate bill.—No provision.

Conference agreement.—The conference agreement includes the House provision.

51. Hospital providers of long-term care services ("swing-beds")

House bill.—The House bill authorizes the Secretary to enter into an agreement with any particpating hospital, for reimbursement purposes, to permit the hospital to use its beds on a "swing-basis" as acute or long-term care beds as needed (reimbursement in such cases would reflect the lower cost of less than acute care).

Where a hospital does not have a "swing-bed" agreement, payment would be made at the same rate otherwise payable to a participating swing-bed hospital for a long-term care patient who cannot be transferred because of the unavailability of a long-term care bed if the hospital's occupancy rate is below 80 percent and the hospital could obtain a certificate of need to provide long-term care services.

Senate amendment.—The Senate amendment provides for reimbursement to hospitals at the SNF or ICF rate (as may be appropriate) for patients in the hospital who are determined to need non-acute services rather than hospital services and where no long-term care bed is available in the locality. This limitation would not apply in geographic areas where the planning agencies certify that

there is no excess of hospital beds and there is a shortage of long-term care beds. The bill also provides medicare reimbursement (with no deductible or coinsurance) for inpatient detoxification services in freestanding facilities meeting health and safety standards.

Conference agreement.—The conference agreement follows the swing-bed provisions of the House bill with modifications so as to limit the availability of swing-bed agreements to rural hospitals of 50 beds or less, and to provide for swing-bed demonstration projects for large and urban hospitals.

Similarly, the conference agreement follows the House bill provisions relating to reimbursement for inappropriate inpatient hospital services with modifications so as to provide that where a beneficiary who no longer requires acute hospital services must remain in the hospital because no long-term care bed is available in the community, the hospital will be reimbursed a daily rate equal to the adjusted average medicaid SNF rate in the State for persons needing SNF services, and for purposes of medicaid at the ICF rate for those patients. (It should be noted that where a State has developed a system of adjustments in its long-term care rates—for example, to distinguish between urban and rural settings—such adjusted rates could be used for purposes of reimbursement under this section where appropriate.) The reduced level of reimbursement would not apply where a hospital's annual occupancy rate is equal to or greater than 80 percent. In determining the occupancy rates of public hospitals under common ownership where patients can be transferred among the related institutions, the rates can be combined (with the approval of the Secretary) for purposes of this occupancy test. Two years after enactment of this legislation, the computation of occupancy rates shall be adjusted, to the extent feasible, to exclude from the computation those long-term care patients who should not be in the hospital.

With respect to the coverage of freestanding detoxification facility services, the conference agreement follows the Senate amendment with modifications so as to limit coverage to alcohol detoxification; to provide for studies and demonstration projects on alcoholism rehabilitation, drug detoxification and incentives for the use of lower-cost free standing detoxification facilities; and to clarify that medicare payment for inpatient detoxification services furnished by participating hospitals to the extent appropriately required and provided would continue to be made as under present law, without regard to the availability of free-standing detoxification facilities.

52. Coordinated audits under the Social Security Act

House bill.—The House bill provides for coordinated audits under medicare and medicaid, and directs the Secretary to evaluate the feasibility of creating a single coordinated appeal process to adjudicate disputes arising under coordinated audits.

Senate amendment.—The Senate amendment includes a similar provision with respect to coordinated audits under medicare and medicaid.

Conference agreement.—The conference agreement includes the House provision.

53. Demonstration projects relating to the training of AFDC recipients as home health aides

House bill.—The House bill requires the Secretary to enter into agreements with up to 12 States for the purpose of conducting demonstration projects for the training and employment of AFDC recipients as home health aides.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill. It is the conferees' intent that in selecting the States for purposes of these demonstrations, the Secretary give priority to those States which have demonstrated active interest in and support for the concept embodied in this provision. (Among the States which have demonstrated such active interest and support are California, Georgia, Hawaii, Michigan, New Jersey, New Mexico and New York.) It is expected that the Secretary will help 12 States to develop effective demonstration projects and will request an increase in the number of States that may participate if, in the Secretary's judgment, the experience with the initial demonstrations warrants such action. Projects shall be inclusive of entire States, or parts of States, depending on the plans proposed by the States; and the number of participants in each State is expected to vary as training and placement opportunities develop over time. Consistent with responsible administration, the conferees expect that the Secretary will act expeditiously in implementing this program with a minimum of regulatory delay and a maximum of formal and informal cooperative effort with applicant States. In any event, the conferees expect that any necessary guidelines (or proposed regulations) will be issued no later than April 1, 1981, and that the opportunity to begin demonstration projects in some States by July 1, 1981 will be made available to those States willing to expeditiously undertake them.

54. Quality assurance programs for clinical laboratories

House bill.—The House bill extends to December 31, 1980, the Secretary's authority to conduct a program to determine the proficiency of clinical laboratory personnel who do not meet formal educational requirements.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision, with an extension through December 31, 1981.

55. Reimbursement of clinical laboratories under medicare and medicaid

House bill.—The House bill limits program recognition of markups of bills from physicians for services performed by independent clinical laboratories; payment to a physician in such cases would be limited to the lesser of the reasonable charge of the laboratory or the amount actually charged the physician, plus a nominal fee for physician handling of the specimen. The House bill also authorizes State medicaid agencies to purchase clinical laboratory services through competitive bidding on a demonstration basis during a 3-year period beginning October 1, 1980.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill with respect to physician billings for clinical laboratory

services; and does not include the House provision relating to the purchase of laboratory services by State medicaid agencies.

56. Reimbursement of physicians' services in teaching hospitals

House bill.—The House bill repeals provisions of existing law that were added by section 227 of P.L. 92-603 under which physicians' services furnished in teaching hospitals are to be treated under medicare as hospital services reimbursable on a reasonable cost basis, except where a hospital had traditionally billed for physicians' services on a charge basis and where the hospital's patients could be considered "private patients." The House bill retains the section 227 provisions of existing law under which a teaching hospital and all its physicians may elect to be paid on the basis of reasonable cost.

Senate amendment.—No provision.

Conference agreement.—The conference agreements follows the House provision by repealing the amendments made by section 227 of P.L. 92-603 except for the provisions allowing cost reimbursement for physicians' services to a hospital with an approved teaching program if the hospital and all its physicians so elect.

In addition, the conference agreement allows reimbursement on a charge basis under medicare part B for the services of a physician in a teaching hospital only if specified conditions are met:

(a) The physician renders sufficient personal and identifiable physician services to the patient to exercise full, personal control over the management of the portion of the case for which the payment is sought and

(b) The services are of the same character as the services the physician furnishes to patients not entitled to benefits under medicare, and

(c) At least 25 percent of the hospital's nonmedicare patients pay all or a substantial part of charges (other than nominal charges) for such services. (In general, the conferees intend that a substantial part of the charges be interpreted as at least 50 percent; however, amounts paid by medicaid would be deemed to meet the "substantial" test.)

In specifying the requirements in (a) and (b), above, the intention of the conferees is to permit payment on a charge basis only where the physician is the patient's "attending physician." The conferees endorse (without intending to prohibit reasonable changes in the future) the attending physician requirements (a portion of which is reproduced below) contained in the existing HHS policy instruction, Intermediary Letter 372.

To be the "attending physician" for an entire period of hosptial care, the teaching physician must as a minimum:

a. Review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and

b. Personally examine the patient; and

c. Confirm or revise the diagnosis and determine the course of treatment to be followed; and

d. Either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level; and

e. Be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; for the physician to be an "attending physician" his presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint; and

f. Be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization.

Where there is an attending physician-patient relationship, as determined pursuant to the above requirements, the customary charges for the services rendered by the attending physician shall be determined in accordance with regulations of the Secretary which take into account the factors cited below:

(i) in the case of a physician who has a substantial practice outside the teaching setting, the medicare carrier shall take into account the amounts the physician charges for similar services in the physician's outside practice;

(ii) in the case of a physician who does not have such a practice as described in clause (i), if the physician, hospital, or other appropriate billing entity has established one or more schedules of charges for medical and surgical services, the carrier shall base reimbursement on the greater of—

(a) the charges (other than nominal charges) which are most frequently collected in full or substantial part from the patients of the hospital who are not entitled to benefits under this title, or

(b) the mean of the charges (other than nominal) collected in full or substantial part from such patients.

Where a physician does not qualify for reimbursement under part A for his services as an attending physician and where the physician elects not to be paid under one of the above payment procedures, the carrier shall base reimbursement on that portion of the physician's compensation from the hospital which is for services to patients determined in accordance with regulations governing reimbursement for the services of hospital-based physicians.

The conferees intend (without precluding reasonable changes in the future) that indetermining the amount payable on a charge basis under medicare part B for services of physicians in teaching hospitals, the policies contained in Intermediary Letter 372 should be generally followed where these are not inconsistent with the provisions of the conference agreement.

The conferees are concerned that existing reimbursement principles on primary care internship or residency programs may work at cross purposes with some provisions of the Public Health Service Act programs which seek to encourage primary care training. The conferees encourage the Secretary of the Department of Health and Human Services, in consultation with the Public Health Service and the Health Care Financing Administration, to study this issue and to provide the appropriate committees of Congress with recommendations for administrative or statutory changes, esti-

mates of costs to government which would be incurred by these changes, and the impact of these changes on primary care teaching programs.

57. Demonstration projects for requiring second opinions for certain elective surgical procedures under medicare and medicaid; application of informed consent to certain demonstration projects

House bill.—The House bill authorizes demonstrations to determine the cost-effectiveness and appropriateness of mandating second opinions, with 100 percent reimbursement, for certain elective surgical procedures; and also provides that no beneficiary shall be required to participate in such a demonstration unless he or she has given informed consent.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

58. Continued use of demonstration project reimbursement systems

House bill.—The House bill requires medicare to continue to reimburse hospitals located in a state which has been conducting a cost containment demonstration in accordance with the system used in the State's demonstration when the demonstration project ends, provided the State program meets certain tests of effectiveness in controlling costs and the State elects to continue the reimbursement system.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill with modifications to provide: (1) that the Secretary is authorized but not required to continue participating in the State's reimbursement system until such time as the State's reimbursement system is no longer applicable to all third-party payors or no longer meets the required tests of effectiveness in controlling costs, except that in the case of any State which has had a cost containment demonstration project reimbursement system in continuous operation since July 1, 1977 (as in the case, for example, of the State of Maryland) the Secretary is required to provide for the continuation of medicare reimbursement in accordance with the State's reimbursement system until the Secretary determines that the State's reimbursement system is no longer applicable to all third party payors or no longer meets the required tests of effectiveness in controlling costs; and (2) the Secretary may establish no more than six Statewide medicare hospital reimbursement demonstration projects, including in this limitation any such projects initiated before the enactment of this legislation.

59. Reimbursement for health maintenance organizations (HMO's)

House bill.—The House bill permits reimbursement to HMO's on the basis of a prospectively determined per capita amount equal to 95 percent of the cost of providing medicare benefits to beneficiaries outside the HMO; the difference between the HMO's community rate and medicare reimbursement would be returned to beneficiaries as additional benefits.

68. Determination of reasonable charge

House bill.—No provision.

Senate amendment.—The Senate amendment provides for medicare reasonable charges to be determined based on the fee schedules in effect as of the date the medical service was rendered rather than the date the medicare claim is processed.

Conference agreement.—The conference agreement includes the Senate provision.

II. MEDICAID-ONLY PROVISIONS

1. Reimbursement under medicaid for services furnished by nurse midwives

House bill.—The House bill requires States to provide coverage under their medicaid programs for services furnished by a nurse midwife which he or she is legally authorized to perform under State law or regulation.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

2. Continuing medicaid eligibility for certain individuals by disregarding certain involuntary increases in income

House bill.—The House bill requires States, in determining the continuing eligibility of beneficiaries of their medicaid programs, to exclude from the calculation of an individual's income any cost-of-living or annual increase in Social Security, Veterans', Railroad Retirement, or Civil Service Retirement benefits, annuities, pensions, or other compensation.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

3. Limitation on medicaid eligibility for individuals who dispose of resources

House bill.—The House bill authorizes States, under their medicaid programs, to delay eligibility for coverage for specified periods of time (up to 24 months, depending upon the amount transferred) if, within 2 years preceding application for coverage, an individual had disposed of resources with an uncompensated value of $6,000 or more for the purpose of establishing medicaid eligibility. The House bill also authorizes States to recover from the individual to whom resources are transferred for less than current market value the lesser of (1) the medicaid payments provided during the period of ineligibility to the person who transferred the assets, or (2) the amount by which the uncompensated value of the resources exceeds $6,000.

Senate amendment.—No provision specific to medicaid. (See Item 1, Public Assistance Provisions, relating to limitations on SSI eligibility for individuals who transfer resources.)

Conference agreement.—The conference agreement does not include the House provision.

4. Adjustment of dollar limitation and elimination of special limitation on medicaid payments to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Somoa, and the Trust Territory of the Pacific Islands

House bill.—The House bill increases the ceilings on Federal medicaid matching payments in fiscal year 1980 to Puerto Rico, and in fiscal years 1981 and 1982 for Puerto Rico, Guam, and the

Virgin Islands. The House bill also provides for an adjustment in these ceilings in subsequent fiscal years by a percent equal to the percentage increase in the Consumer Price Index, and for the determination of the Federal medicaid matching rates in these jurisdictions on the same basis as in other States. The House bill further authorizes participation in medicaid by the Northern Mariana Islands, American Samoa, and the Trust Territory of the Pacific Islands, with Federal matching payments subject to an annual ceiling with adjustments for inflation.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

5. Extension of increased funding for long-term care facility inspectors under medicaid

House bill.—The House bill extends from September 30, 1980, through September 30, 1983 the 100 percent Federal matching rate for the costs of training and compensating State personnel responsible for conducting inspections of skilled nursing facilities and intermediate care facilities participating in medicaid to assure compliance with health and safety standards.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

6. Extension of increased funding for State medicaid fraud control units

House bill.—The House bill authorizes Federal matching payments to the States for the costs of establishing and operating medicaid fraud control units meeting specified requirements at the rate of 90 percent for the initial 3-year period and 75 percent thereafter, subject to a quarterly limitation of the higher of $125,000 or one-quarter of one percent of total medicaid expenditures in the State in the previous quarter.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

7. Change in calendar quarter for which satisfactory utilization review must be shown to receive waiver or medicaid reduction

House bill.—The House bill prohibits the Secretary from assessing financial penalties against the States for failure to meet the requirements of medicaid law regarding utilization review of long-term services in institutional settings for periods prior to January, 1978.

Senate amendment.—No provision.

Conference agreement.—The conference agreement includes the House provision.

8. Expedited recovery for certain disallowed medicaid claims

House bill.—The House bill provides for recovery by the Secretary of Federal matching payments for State medicaid expenditures which are disallowed on or after October 1, 1980 by offsetting payments to the State which occur subsequent to the final notice of

disallowance. The House bill requires the Secretary to give a preliminary notice to the State of the intention to disallow payments at least 30 days prior to the date of the final notice of disallowance. If, upon conclusion of all appeals, the Secretary's disallowance is overturned, the House bill provides that the State be paid the amount disallowed plus interest (at a rate based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during such period).

Senate amendment.—The Senate amendment provides for recovery by the Secretary of Federal matching payments for State medicaid expenditures which are disallowed on or after enactment by offsetting payments to the State which occur subsequent to the disallowance. If, upon conclusion of all appeals, the Secretary's disallowance is overturned, the Senate amendment provides that the amount disallowed be returned to the State with interest (at a rate equal to that on obligations issued for purchase by the Federal Hospital Insurance Trust Fund).

Conference agreement.—The conference agreement follows the House bill with a modification that authorizes States, after a final notice of disallowance by the Secretary, to retain Federal matching payments for all disallowed expenditures until the conclusion of the administrative appeals process. If the final administrative determination upholds the Secretary's disallowance, the conference agreement provides that the State must return the Federal payments to the Secretary, with interest (at a rate based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during such period). With respect to notices of disallowance issued during fiscal year 1981, the States would be subject to interest penalties for no more than 12 months, regardless of the amount of time required to conclude the administrative appeals process. With respect to notices of disallowance issued after fiscal year 1981, the maximum period for which a State would be subject to interest penalties would be six months. In limiting the amount of interest recoverable by the Secretary in this manner, the conferees intend that the Secretary expedite the processing of State appeals from notices of disallowance. The provision is effective for disallowances of expenditures for services rendered on or after October 1, 1980.

9. Access to and purchase of medicaid services

House bill.—No provision. (See description of Item 55, Reimbursement of Clinical Laboratories under Medicare and Medicaid, under the House bill, relating to the purchase of laboratory services under medicaid.)

Senate amendment.—The Senate amendment deletes the provision in current medicaid law that entitles beneficiaries to obtain medical assistance from any institution, agency, community pharmacy, or person qualified to perform the covered service and instead authorizes States to limit or restrict beneficiary choice of institutional providers (including clinics), laboratory services, and medical devices. Under the Senate amendment, such limitations or restrictions must be cost-effective, assure reasonable access to services, and avoid a substantially adverse effect on access to hospitals with graduate medi al education programs.

Conference agreement.—The conference agreement does not include the Senate provision.

10. Reimbursement rates under medicaid for skilled nursing and intermediate care facilities

House bill.—No provision.

Senate amendment.—The Senate amendment deletes the requirement in current law that SNFs and ICFs participating in the medicaid program be reimbursed on a reasonable cost-related basis and substitutes the requirement that States reimburse SNF and ICF services at rates that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

Conference agreement.—The conference agreement follows the Senate amendment with a modification to clarify that, while the States have discretion to develop the methods and standards on which the rates of reimbursement are based, the Secretary retains final authority to review the rates and to disapprove those rates if they do not meet the requirements of the statute. The conferees intend that the Secretary exercise this review in a timely fashion. If, within 90 days of receiving the rates proposed to be used by a State, the Secretary has not made a final determination that the rates proposed meet all applicable requirements of medicaid law, then the rates would be presumed to meet the medicaid law requirements for the fiscal year for which they were proposed. The conferees would further note their intent that a State not develop rates under this section solely on the basis of budgetary appropriations. In determining whether the rates proposed by a State are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities, the Secretary is not expected to approve a rate lower than the applicable legal requirements would mandate.

I. PUBLIC ASSISTANCE PROVISIONS

1. Limitation on SSI eligibility for individuals who transfer resources

House bill.—No provision.

Senate amendment.—The Senate amendment would delay SSI eligibility in the case of an individual or eligible spouse who transferred resources for less than fair market value, if retaining such resources would have made them ineligible for SSI benefits. Such a transfer would cause a delay in eligibility of 24 months from the date of the disposal of the resources.

For 24 months after the transfer of resources, it would be presumed that the transfer had been made for the purpose of establishing eligibility for benefits or assistance under the Social Security Act (e.g., SSI, medicaid) unless such individual or eligible spouse furnishes convincing evidence to establish that the transaction was exclusively for some other purpose.

The provision would be effective with respect to applications for benefits filed on or after October 1, 1980.

Conference agreement.—The conference agreement does not include the Senate provision.

2. Delay in effective date of new HHS title XX child day care regulations

House bill.—No provision.

Senate amendment.—The Senate amendment provides that the standards for child day care services required under Title XX of the Social Security Act, or promulgated by the Department of HHS pursuant to Title XX, would not be applicable to child day care services provided during the period of July 1, 1980 to October 1, 1981, if the services meet applicable standards of State and local law.

Conference agreement.—The conference agreement follows the Senate amendment with an amendment which provides that the standards for child day care services required under Title XX law, or promulgated by the Department of HHS, would not be applicable to child day care services provided during the period of July 1, 1980 to July 1, 1981, if such services meet applicable standards of State and local law.

The agreement also provides that the Department of Health and Human Services shall assist each State in conducting a systematic assessement of current practices in Title XX funded day care programs and provide a summary report of the assessments to Congress by June 1, 1981.

3. Public assistance payments to territorial jurisdictions

House bill.—No provision.

Senate amendment.—The Senate amendment would reduce the ceiling on Federal matching funds for public assistance programs in Puerto Rico, Guam and the Virgin Islands from the fiscal 1979

II. SOCIAL SECURITY PROVISIONS

1. Reallocation of taxes between OASI and DI trust funds

House bill.—No provision. However, the House passed separate legislation, H.R. 7670, (which contains language identical to the Senate amendment) on July 21, 1980.

Senate amendment.—The Senate amendment provides for a two year reallocation of OASDI tax revenues into the OASI and DI trust funds. The reallocation would increase revenues to the OASI trust fund and decrease them for the DI trust fund and would apply to calendar years 1980 and 1981 only.

Conference agreement.—The conference agreement does not include the Senate provision. Reallocation provisions identical to the Senate provision were passed by the Senate September 25, 1980 (H.R. 7670) and enacted into law on October 9, 1980 (P.L. 96-403).

2. Limitation on payment of retroactive social security benefits

House bill—No provision.

Senate amendment.—The Senate amendment limits the retroactive payment of social security benefits to a period of 3 months prior to the month in which application for benefits is made, decreasing the period from 12 months under present law.

Conference agreement.—The conference agreement limits benefit retroactivity to a period of 6 months prior to the month in which application for benefits is made, except for applications filed for disability benefits by disabled workers (and all family benefits thereunder) or benefits for disabled widows and widowers. Benefits applications for disabled workers, their dependents and disabled widow(er)s will continue to be made retroactive for up to 12 months as under present law. The provision is effective on the first day of the first month beginning 60 days after enactment.

3. Social security benefits for prisoners

House bill.—No provision.

Senate amendment.—The Senate amendment requires the suspension of workers and children's disability benefits to any individual who would otherwise be receiving them while he is imprisoned by reason of a felony conviction. The suspension applies except to the extent that a court of law specifically provides to the contrary as part of its approval of a plan of rehabilitation services to that individual. The exemption from suspension would last only for so long as the individual continues to participate satisfactorily in such rehabilitation program, which (as determined by the Secretary) is expected to result in his return to substantial gainful employment within a reasonable time after his release. Dependents' benefits would continue to be paid. The amendment also provides that an individual may not be considered to be a full-time student for purposes of social security student benefits while he is incarcerated. In addition, the amendment provides that disabilities to the extent that they arise from or are aggravated during the commission of a crime may not be considered in determining whether or not an individual qualifies for disability benefits. Impairments arising while an individual is in prison could not be considered for purposes of disability eligibility so long as the individual remains in prison.

Finder's Aid

P.L. 96-611 (94 Stat. 3566) Approved December 28, 1980
Social Security Act, Amendment

Subject	SS Act Section	P.L. Section	94 Stat.	No Legislative Reports
Definition of "dependent child" - Status of student at option of the State	406(a)(2)(B)	4(1)	3567	
Definition of "dependent child" - Status of student in grade 12 or below at option of the State.	406(a)(2)(C) (new)	4(2)	3567	
State Plan for Child Support (Technical Amendment)	454(15)	9(a)(1)	3571	
State Plan for Child Support (Technical Amendment)	454(16)	9(a)(2)	3571	
State Plan for Child Support Fees for Costs of Funding Information Per Agreement With States in Custody and Parental Kidnaping Cases	454(17) (new)	9(a)(3)	3571	
Payments to States Excludes Payment of Costs of Carrying Out Agreements in Custody and Parental Kidnaping Cases	455(a)	9(c)	3573	
Payments to States (Technical Amendment)	455(a)	11(c)	3574	
Use of Parent Locator Service in Custody and Parental Kidnaping Cases	463 (new)	9(b)	3572	
Payments to States For Adoption Assistance and Foster Care	474(d) (new)	3	3567	
Disposal of Resources at Less Than Fair Market Value--Inclusion as Resources	1613(c) (new)	5(a)	3567	
Payment of Benefits (Technical Amendment)	1833(a)(1)(F)	1(b)(1)(A)	3566	
Payment of Benefits - 100% of Reasonable Charges for Pneumococcal Vaccine and its Administration	1833(a)(1)(H) (new)	1(b)(1)(B)	3567	
Payment of Benefits - Reasonable Cost of Pneumococcal Vaccine and its Administration	1833(a)(2)(A)	1(b)(1)(C)	3566	
Payment of Benefits - (Technical Amendment) - Pneumococcal Vaccine and its Administration	1833(a)(3)	1(b)(1)(D)	3566	

BEST DOCUMENT AVAILABLE

Subject	SS Act Section	P.L. Section	94 Stat.	No Legislative Reports
Payment of Benefits - (Technical Amendment) - Pneumococcal Vaccine and its Administration	1833(b)(2)	1(b)(2)	3566	
Medical and Other Health Services (Technical Amendment)	1861(s)(8)	1(a)(1)(B)	3566	
Medical and Other Health Services (Technical Amendment)	1861(s)(9)	1(a)(1)(C)	3566	
Medical and Other Health Services (Technical Amendment)	1861(s)(10)	1(a)(1)(A)	3566	
Medical and Other Health Services - Adds Pneumococcal Vaccine and its Administration	1861(s)(10) (new)	1(a)(1)(D)	3566	
Medical and Other Health Services (Technical Amendment)	1861(s)(11)	1(a)(1)(A)	3566	
Medical and Other Health Services (Technical Amendment)	1861(s)(12)	1(a)(1)(A)	3566	
Medical and Other Health Services (Technical Amendment)	1861(s)(13)	1(a)(1)(A)	3566	
Rival Health Clinic Services - Adds Pneumococcal Vaccine and its Administration	1861(aa)(1)(A)	1(b)(3)	3566	
Exclusion From Coverage - (Technical Amendment) - Pneumococcal Vaccine and its Administration	1862(a)(1)	1(a)(3)(A)	3566	
Exclusion From Coverage - (Technical Amendment) - Pneumococcal Vaccine and its Administration	1862(a)(7)	1(a)(3)(B)	3566	
Use of State Agencies to Determine Compliance by Providers of Services with Conditions of Participation (Technical Amendment)	1864(a)	1(a)(2)	3566	
Agreements with Providers of Services - (Technical Amendment) - Pneumococcal Vaccine and its Administration	1866(a)(2)(A)	1(b)(4)	3566	
State Plans for Medical Assistance - Adds Provision for Inclusion of Resources Disposed of for Less Than Fair Market Value	1902(j) (new)	5(b)	3568	

BEST DOCUMENT AVAILABLE

SOCIAL SECURITY ACT, AMENDMENT

944

Public Law 96-611
96th Congress

An Act

Dec. 28, 1980
[H.R. 8406]

To amend title XVIII of the Social Security Act to provide for medicare coverage of pneumococcal vaccine and its administration.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a)(1) section 1861(s) of the Social Security Act is amended—

Social Security Act, amendment.
42 USC 1395x.

(A) by redesignating paragraphs (10) through (13) as paragraphs (11) through (14), respectively;

(B) by striking out "and" at the end of paragraph (8);

(C) by striking out the period at the end of paragraph (9) and inserting in lieu thereof "; and"; and

(D) by inserting after paragraph (9) the following paragraph: "(10) pneumococcal vaccine and its administration.".

42 USC 1395aa.

(2) Section 1864(a) of such Act is amended by striking out "paragraphs (10) and (11) of section 1861(s)" and inserting in lieu thereof "paragraphs (11) and (12) of section 1861(s)".

42 USC 1395y.

(3) Section 1862(a) of such Act is amended—

(A) by inserting ", or, in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness" before the semicolon at the end of paragraph (1), and

(B) by inserting "(except as otherwise allowed under section 1861(s)(10) and paragraph (1))" in paragraph (7) after "immunizations".

42 USC 1395*l*.

(b)(1) Section 1833(a) of such Act (as amended by sections 932(a)(1)(B), 934(d), and 942 of the Medicare and Medicaid Amendments of 1980) is amended—

Ante, pp. 2634, 2239, 2641.

(A) by striking out "and" before "(G)" in paragraph (1);

(B) by inserting at the end of paragraph (1) the following: "and (H) with respect to items and services described in section 1861(s)(10), the amounts paid shall be 100 percent of the reasonable charges for such items and services,";

(C) by inserting "and to items and services described in section 1861(s)(10)" in paragraph (2)(A) after "home health services"; and

(D) by inserting "(other than for items and services described in section 1861(s)(10))" in paragraph (3) after "but in no case may the payment for such services".

(2) The first sentence of section 1833(b) of such Act is amended by inserting "(A)" in clause (2) after "expenses incurred", and by inserting before the comma at the end of such clause the following: ", or (B) for items and services described in section 1861(s)(10)".

(3) Subparagraph (A) of section 1861(aa)(1) of such Act is amended by inserting before the comma at the end the following: "and items and services described in section 1861(s)(10)".

42 USC 1395cc.

(4) Section 1866(a)(2)(A) of such Act is amended by adding at the end the following new sentence: "A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10) for which payment is made under part B.".

945

SEC. 2. The amendments made by this Act shall take effect on, and apply to services furnished on or after, July 1, 1981. Effective date. 42 USC 1395l note.

PAYMENTS TO STATES FOR ADOPTION ASSISTANCE AND FOSTER CARE

SEC. 3. Section 474 of the Social Security Act is amended by adding at the end the following new subsection: 42 USC 674.

"(d)(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to which a State will be entitled under subsections (a), (b), and (c) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of children in the State receiving assistance under this part, and (c) such other investigation as the secretary may find necessary. Estimates, State entitlement.

"(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

"(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to foster care and adoption assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.". Pro rata share.

SEC. 4. Section 406(a)(2) of the Social Security Act is amended— 42 USC 606.

(1) by inserting "at the option of the State," after "(B)"; and

(2) by inserting before the semicolon at the end thereof the following: ", or (C) at the option of the State, under the age of twenty-one and (as determined by the State in accordance with standards prescribed by the Secretary) a student regularly attending a school in grade twelve or below or regularly attending a course of vocational or technical training, other than a course provided by or through a college or university, designed to fit him for gainful employment".

SEC. 5. (a) Section 1613 of the Social Security Act is amended by adding at the end thereof the following new subsection: 42 USC 1382b.

"DISPOSAL OF RESOURCES FOR LESS THAN FAIR MARKET VALUE

"(c)(1) In determining the resources of an individual (and his eligible spouse, if any) there shall be included (but subject to the exclusions under subsection (a)) any resource (or interest therein) owned by such individual or eligible spouse within the preceding 24 months if such individual or eligible spouse gave away or sold such resource or interest at less than fair market value of such resource or interest for the purpose of establishing eligibility for benefits or assistance under this Act.

"(2) Any transaction described in paragraph (1) shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under this Act unless such individual or eligible spouse Eligibility benefits.

furnishes convincing evidence to establish that the transaction was exclusively for some other purpose.

Fair market value or interest

"(3) For purposes of paragraph (1) the value of such a resource or interest shall be the fair market value of such resource or interest at the time it was sold or given away, less the amount of compensation received for such resource or interest, if any.".

42 USC 1396a

(b) Section 1902 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(j)(1) Notwithstanding any other provision of this title, an individual who would otherwise be eligible for medical assistance under the State plan approved under this title may be denied such assistance if such individual would not be eligible for such medical assistance but for the fact that he disposed of resources for less than fair market value. If the State plan provides for the denial of such assistance by reason of such disposal of resources, the State plan shall specify a procedure for implementing such denial which, except as provided in paragraph (2), is not more restrictive than the procedure specified in section 1613(c) of this Act.

Ante, p. 3567.

Ineligibility period

"(2) In any case where the uncompensated value of disposed of resources exceeds $12,000, the State plan may provide for a period of ineligibility which exceeds 24 months. If a State plan provides for a period of ineligibility exceeding 24 months, such plan shall provide for the period of ineligibility to bear a reasonable relationship to such uncompensated value.

Medical assistance, ligibility

"(3) In any case where an individual is ineligible for medical assistance under the State plan solely because of the applicability to such individual of the provisions of section 1613(c), the State plan may provide for the eligibility of such individual for medical assistance under the plan if such individual would be so eligible if the State plan requirements with respect to disposal of resources applicable under paragraphs (1) and (2) of this subsection were applied in lieu of the provisions of section 1613(c).".

Effective date. 2 USC 1382b note. 42 USC 1601

(c) The amendment made by subsection (a) shall be effective with respect to applications for benefits under title XVI of the Social Security Act filed on or after the first day of the first month which begins at least 60 days after the date of enactment of this Act.

SHORT TITLE

42 USC 1305 note.

SEC. 6. Sections 6 to 10 of this Act may be cited as the "Parental Kidnaping Prevention Act of 1980".

FINDINGS AND PURPOSES

28 USC 1738A note.

SEC. 7. (a) The Congress finds that—

(1) there is a large and growing number of cases annually involving disputes between persons claiming rights of custody and visitation of children under the laws, and in the courts, of different States, the District of Columbia, the Commonwealth of Puerto Rico, and the territories and possessions of the United States;

(2) the laws and practices by which the courts of those jurisdictions determine their jurisdiction to decide such disputes, and the effect to be given the decisions of such disputes by the courts of other jurisdictions, are often inconsistent and conflicting;

(3) those characteristics of the law and practice in such cases, along with the limits imposed by a Federal system on the authority of each such jurisdiction to conduct investigations and

take other actions outside its own boundaries, contribute to a tendency of parties involved in such disputes to frequently resort to the seizure, restraint, concealment, and interstate transportation of children, the disregard of court orders, excessive relitigation of cases, obtaining of conflicting orders by the courts of various jurisdictions, and interstate travel and communication that is so expensive and time consuming as to disrupt their occupations and commercial activities; and

(4) among the results of those conditions and activities are the failure of the courts of such jurisdictions to give full faith and credit to the judicial proceedings of the other jurisdictions, the deprivation of rights of liberty and property without due process of law, burdens on commerce among such jurisdictions and with foreign nations, and harm to the welfare of children and their parents and other custodians.

National system of locating parents, establishment.

(b) For those reasons it is necessary to establish a national system for locating parents and children who travel from one such jurisdiction to another and are concealed in connection with such disputes, and to establish national standards under which the courts of such jurisdictions will determine their jurisdiction to decide such disputes and the effect to be given by each such jurisdiction to such decisions by the courts of other such jurisdictions.

(c) The general purposes of sections 6 to 10 of this Act are to—

(1) promote cooperation between State courts to the end that a determination of custody and visitation is rendered in the State which can best decide the case in the interest of the child;

(2) promote and expand the exchange of information and other forms of mutual assistance between States which are concerned with the same child;

(3) facilitate the enforcement of custody and visitation decrees of sister States;

(4) discourage continuing interstate controversies over child custody in the interest of greater stability of home environment and of secure family relationships for the child;

(5) avoid jurisdictional competition and conflict between State courts in matters of child custody and visitation which have in the past resulted in the shifting of children from State to State with harmful effects on their well-being; and

(6) deter interstate abductions and other unilateral removals of children undertaken to obtain custody and visitation awards.

FULL FAITH AND CREDIT GIVEN TO CHILD CUSTODY DETERMINATIONS

SEC. 8. (a) Chapter 115 of title 28, United States Code, is amended by adding immediately after section 1738 the following new section:

28 USC 1731 *et seq.*

"§1738A. Full faith and credit given to child custody determinations

28 USC 1738A.

"(a) The appropriate authorities of every State shall enforce according to its terms, and shall not modify except as provided in subsection (f) of this section, any child custody determination made consistently with the provisions of this section by a court of another State.

Definitions.

"(b) As used in this section, the term—

"(1) 'child' means a person under the age of eighteen;

"(2) 'contestant' means a person, including a parent, who claims a right to custody or visitation of a child;

"(3) 'custody determination' means a judgment, decree, or other order of a court providing for the custody or visitation of a

child, and includes permanent and temporary orders, and initial orders and modifications;

"(4) 'home State' means the State in which, immediately preceding the time involved, the child lived with his parents, a parent, or a person acting as parent, for at least six consecutive months, and in the case of a child less than six months old, the State in which the child lived from birth with any of such persons. Periods of temporary absence of any of such persons are counted as part of the six-month or other period;

"(5) 'modification' and 'modify' refer to a custody determination which modifies, replaces, supersedes, or otherwise is made subsequent to, a prior custody determination concerning the same child, whether made by the same court or not;

"(6) 'person acting as a parent' means a person, other than a parent, who has physical custody of a child and who has either been awarded custody by a court or claims a right to custody;

"(7) 'physical custody' means actual possession and control of a child; and

"(8) 'State' means a State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or possession of the United States.

"(c) A child custody determination made by a court of a State is consistent with the provisions of this section only if—

"(1) such court has jurisdiction under the law of such State; and

"(2) one of the following conditions is met:

"(A) such State (i) is the home State of the child on the date of the commencement of the proceeding, or (ii) had been the child's home State within six months before the date of the commencement of the proceeding and the child is absent from such State because of his removal or retention by a contestant or for other reasons, and a contestant continues to live in such State;

"(B)(i) it appears that no other State would have jurisdiction under subparagraph (A), and (ii) it is in the best interest of the child that a court of such State assume jurisdiction because (I) the child and his parents, or the child and at least one contestant, have a significant connection with such State other than mere physical presence in such State, and (II) there is available in such State substantial evidence concerning the child's present or future care, protection, training, and personal relationships;

"(C) the child is physically present in such State and (i) the child has been abandoned, or (ii) it is necessary in an emergency to protect the child because he has been subjected to or threatened with mistreatment or abuse;

"(D)(i) it appears that no other State would have jurisdiction under subparagraph (A), (B), (C), or (E), or another State has declined to exercise jurisdiction on the ground that the State whose jurisdiction is in issue is the more appropriate forum to determine the custody of the child, and (ii) it is in the best interest of the child that such court assume jurisdiction; or

"(E) the court has continuing jurisdiction pursuant to subsection (d) of this section.

"(d) The jurisdiction of a court of a State which has made a child custody determination consistently with the provisions of this section continues as long as the requirement of subsection (c)(1) of this

section continues to be met and such State remains the residence of the child or of any contestant.

"(e) Before a child custody determination is made, reasonable notice and opportunity to be heard shall be given to the contestants, any parent whose parental rights have not been previously terminated and any person who has physical custody of a child.

"(f) A court of a State may modify a determination of the custody of the same child made by a court of another State, if—

"(1) it has jurisdiction to make such a child custody determination; and

"(2) the court of the other State no longer has jurisdiction, or it has declined to exercise such jurisdiction to modify such determination.

"(g) A court of a State shall not exercise jurisdiction in any proceeding for a custody determination commenced during the pendency of a proceeding in a court of another State where such court of that other State is exercising jurisdiction consistently with the provisions of this section to make a custody determination.".

(b) The table of sections at the beginning of chapter 115 of title 28, United States Code, is amended by inserting after the item relating to section 1738 the following new item: 28 USC 1738A note. *Ante*, p. 3569.

"1738A. Full faith and credit given to child custody determinations.".

(c) In furtherance of the purposes of section 1738A of title 28, United States Code, as added by subsection (a) of this section, State courts are encouraged to—

(1) afford priority to proceedings for custody determinations; and

(2) award to the person entitled to custody or visitation pursuant to a custody determination which is consistent with the provisions of such section 1738A, necessary travel expenses, attorneys' fees, costs of private investigations, witness fees or expenses, and other expenses incurred in connection with such custody determination in any case in which— *Ante*, p. 3569.

(A) a contestant has, without the consent of the person entitled to custody or visitation pursuant to a custody determination which is consistent with the provisions of such section 1738A, (i) wrongfully removed the child from the physical custody of such person, or (ii) wrongfully retained the child after a visit or other temporary relinquishment of physical custody; or

(B) the court determines it is appropriate.

USE OF FEDERAL PARENT LOCATOR SERVICE IN CONNECTION WITH THE ENFORCEMENT OR DETERMINATION OF CHILD CUSTODY AND IN CASES OF PARENTAL KIDNAPING OF A CHILD

SEC. 9. (a) Section 454 of the Social Security Act is amended— 42 USC 654.

(1) by striking out "and" at the end of paragraph (15);

(2) by striking out the period at the end of paragraph (16) and inserting in lieu thereof "; and"; and

(3) by inserting after paragraph (16) the following new paragraph:

"(17) in the case of a State which has in effect an agreement with the Secretary entered into pursuant to section 463 for the use of the Parent Locator Service established under section 453, to accept and transmit to the Secretary requests for information authorized under the provisions of the agreement to be furnished by such Service to authorized persons, and to impose and collect (in accordance with *Post*, p. 3572. 42 USC 653.

regulations of the Secretary) a fee sufficient to cover the costs to the State and to the Secretary incurred by reason of such requests, to transmit to the Secretary from time to time (in accordance with such regulations) so much of the fees collected as are attributable to such costs to the Secretary so incurred, and during the period that such agreement is in effect, otherwise to comply with such agreement and regulations of the Secretary with respect thereto.".

42 USC 651 (b) Part D of title IV of the Social Security Act is amended by adding at the end thereof the following new section:

"USE OF FEDERAL PARENT LOCATOR SERVICE IN CONNECTION WITH THE ENFORCEMENT OR DETERMINATION OF CHILD CUSTODY AND IN CASES OF PARENTAL KIDNAPING OF A CHILD

42 USC 663 "SEC. 463. (a) The Secretary shall enter into an agreement with any State which is able and willing to do so, under which the services of the Parent Locator Service established under section 453 shall be made available to such State for the purpose of determining the whereabouts of any absent parent or child when such information is to be used to locate such parent or child for the purpose of—

"(1) enforcing any State or Federal law with respect to the unlawful taking or restraint of a child; or

"(2) making or enforcing a child custody determination.

"(b) An agreement entered into under this section shall provide 42 USC 654 that the State agency described in section 454 will, under procedures prescribed by the Secretary in regulations, receive and transmit to the Secretary requests from authorized persons for information as to (or useful in determining) the whereabouts of any absent parent or child when such information is to be used to locate such parent or child for the purpose of—

"(1) enforcing any State or Federal law with respect to the unlawful taking or restraint of a child; or

"(2) making or enforcing a child custody determination.

"(c) Information authorized to be provided by the Secretary under this section shall be subject to the same conditions with respect to disclosure as information authorized to be provided under section 42 USC 653 453, and a request for information by the Secretary under this section shall be considered to be a request for information under section 453 which is authorized to be provided under such section. Only information as to the most recent address and place of employment of any absent parent or child shall be provided under this section.

Definitions. "(d) For purposes of this section—

"(1) the term 'custody determination' means a judgment, decree, or other order of a court providing for the custody or visitation of a child, and includes permanent and temporary orders, and initial orders and modification;

"(2) the term 'authorized person' means—

"(A) any agent or attorney of any State having an agreement under this section, who has the duty or authority under the law of such State to enforce a child custody determination;

"(B) any court having jurisdiction to make or enforce such a child custody determination, or any agent of such court; and

"(C) any agent or attorney of the United States, or of a State having an agreement under this section, who has the duty or authority to investigate, enforce, or bring a prosecu-

tion with respect to the unlawful taking or restraint of a child.".

(c) Section 455(a) of such Act is amended by adding after paragraph (3) the following: "except that no amount shall be paid to any State on account of amounts expended to carry out an agreement which it has entered into pursuant to section 463.". 42 USC 655.

Ante, p. 3572.

(d) No agreement entered into under section 463 of the Social Security Act shall become effective before the date on which section 1738A of title 28, United States Code (as added by this title) becomes effective. Effective date. 42 USC 663 note. *Ante*, p. 3569.

PARENTAL KIDNAPING

SEC. 10. (a) In view of the findings of the Congress and the purposes of sections 6 to 10 of this Act set forth in section 302, the Congress hereby expressly declares its intent that section 1073 of title 18, United States Code, apply to cases involving parental kidnaping and interstate or international flight to avoid prosecution under applicable State felony statutes. 18 USC 1073 note. 42 USC 502.

(b) The Attorney General of the United States, not later than 120 days after the date of the enactment of this section (and once every 6 months during the 3-year period following such 120-day period), shall submit a report to the Congress with respect to steps taken to comply with the intent of the Congress set forth in subsection (a). Each such report shall include—

(1) data relating to the number of applications for complaints under section 1073 of title 18, United States Code, in cases involving parental kidnaping;

(2) data relating to the number of complaints issued in such cases; and

(3) such other information as may assist in describing the activities of the Department of Justice in conformance with such intent.

TECHNICAL AMENDMENTS AND AMENDMENTS RELATING TO CHILD SUPPORT AUDITS

SEC. 11. (a)(1) Section 127(a)(1) of the Food Stamp Act Amendments of 1980 (Public Law 96-249), is amended by striking out "Subsection (i) of section 6103" and inserting in lieu thereof "Subsection (l) of section 6103". *Ante*, p. 365.

(2)(A) Section 408(a)(1) of the Social Security Disability Amendments of 1980 (Public Law 96-265), is amended by striking out (in the new paragraph added thereby to subsection (l) of section 6103 of the Internal Revenue Code of 1954) "(7) Disclosure" and inserting in lieu thereof "(8) Disclosure". *Ante*, p. 468.

(B) Section 408(a)(2) of the Social Security Disability Amendments of 1980 is amended—

(i) in subparagraph (A), by—

(I) striking out "(l)(1) or (4)(B) or (5)" and inserting in lieu thereof "(l)(1), (4)(B), (5), or (7)", and

(II) striking out "(l)(1), (4)(B), (5), or (7)" and inserting in lieu thereof "(l)(1), (4)(B), (5), (7), or (8)";

(ii) in subparagraph (B), by—

(I) striking out "(l) (3) or (6)" and inserting in lieu thereof "(l) (3), (6), or (7)", and

(II) striking out "(l) (3), (6), or (7)" and inserting in lieu thereof "(l) (3), (6), (7), or (8)";

(iii) in subparagraph (C), by—

(I) striking out "(l)(6)" and inserting in lieu thereof "(l) (6) or (7)", and

(II) striking out "(l) (6) or (7)" and inserting in lieu thereof "(l) (6), (7), or (8)"; and

26 USC 7213. (iv) in subparagraph (D), by—

(I) striking out "subsection (d), (l)(6) or (m)(4)(B)" and inserting in lieu thereof "subsection (d), (l) (6) or (7), or (m)(4)(B)", and

(II) striking out "subsection (d), (l) (6) or (7), or (m)(4)(B)" and inserting in lieu thereof "subsection (d), (l) (6), (7), or (8), or (m)(4)(B)".

Effective date. 26 USC 6103 note. (3) The amendment made by paragraph (1) shall take effect on May 26, 1980 and the amendments made by paragraph (2) shall take effect on June 9, 1980.

26 USC 7213. (4)(A) The first sentence of section 7213(a)(2) of the Internal Revenue Code of 1954 (relating to unauthorized disclosure of information by State and other employees) is amended by striking out "(l) (6) or (7)" and inserting in lieu thereof "(l) (6), (7), or (8)".

Effective date. 26 USC 7213 note. (B) The amendment made by subparagraph (A) shall take effect on December 5, 1980.

Ante, p. 532. (b)(1) Section 309 of the Adoption Assistance and Child Welfare Act of 1980 is amended by striking out "fiscal year 1977 or fiscal year 1978 shall be made prior to October 1, 1980" and inserting in lieu thereof "any of the fiscal years 1977 through 1980 shall be made prior to October 1, 1981".

(2) The regulations pertaining to audit criteria (as set forth in 45 CFR 305.20) and the regulations pertaining to penalty for failure to have an effective child support enforcement program (as set forth in 45 CFR 305.50), under the child support program established by title

42 USC 651. IV-D of the Social Security Act, as in effect on the date of enactment of this Act, shall remain in effect until October 1, 1981.

42 USC 655. (c) Section 455(a) of the Social Security Act is amended by striking out the semicolon at the end thereof and inserting in lieu thereof a period.

Approved December 28, 1980.

LEGISLATIVE HISTORY:

CONGRESSIONAL RECORD, Vol. 126 (1980):
Dec. 5, considered and passed House.
Dec. 13, considered and passed Senate, amended; House agreed to Senate amendments.

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